From Isolated Asylums to the Medical Mainstream: Psychiatry's Journey Towards Normalization within Somatic Medicine, 1900-1970.

by Alex Myrick

A Thesis Submitted to
Saint Mary's University, Halifax, Nova Scotia
in Partial Fulfilment of the Requirements for
the Degree of Master of Arts in History.

18 November 2020, Halifax, Nova Scotia

Approved:	Dr. Peter Twohig Supervisor
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Date:	18 November 2020

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Abstract

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Early in the twentieth century, therapeutic pessimism gripped psychiatry as chronic patients overcrowded mental asylums. Psychiatry grew isolated from the rest of medicine and many feared the specialty was medically irrelevant. Psychiatrist Adolf Meyer devised reforms that would integrate psychiatry into medical schools and general hospitals. This was meant to remove the stigma attached to mental illness and asylums. Moreover, psychiatrists would form productive relationships with somatic physicians which they lacked in asylum practice. This transition, however, was challenged by physicians who argued that the mentally ill had no place in their institutions. Through Meyer's reforms, psychiatry's role in medicine and society was altered, and a process of psychiatric normalization ensued across North America. A close examination of this transformation in Nova Scotia provides a case study that demonstrates how Meyer's ideas spread via medical journals, and through students such as Dr. Robert O. Jones, who implemented Meyer's reform strategy.

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Acknowledgements

My deepest gratitude goes first to Dr. Peter Twohig, my thesis supervisor. Without your encouragement and guidance this thesis would not have taken shape. Gathering together my ideas and making sense of the evidence was a daunting challenge. I felt overwhelmed at times and struggled to keep this project focused. Because of Dr. Twohig's endless patience, incisive edits, and unwavering support, along with healthy dosages of constructive criticism, this thesis has finally become the product which we envisioned. I truly cannot extend enough thanks to Dr. Twohig for all of his help and wisdom.

I am also indebted to honours coordinator Dr. Nicole Neatby who aided greatly in the early stages of my research, and Dr. Kirrily Freeman who helped refine this project as graduate coordinator. Thanks to Dr. Blake Brown as well. It was a pleasure serving as your research assistant. Additionally, Dr. Leslie Digdon took a keen interest in my work and I will always appreciate her for that. Then to Dr. John Reid, Dr. Michael Vance, Dr. Karly Kehoe, and all professors who I had the pleasure of taking classes with, thank you. I am convinced that the warm and stimulating atmosphere throughout the Saint Mary's History Department played a pivotal role in my personal and professional growth.

The Faculty of Graduate Studies and Research have my gratitude as their generous financial support allowed me to focus on my work. Furthermore, the library staff at Saint Mary's were tremendously helpful as they tracked down every item I requested. I also appreciate the assistance which the Dalhousie University archivists provided during my research.

A special thanks goes to Dr. Susan Lamb at the University of Ottawa whose knowledge on Adolf Meyer is unmatched. Our correspondences over the past year greatly benefitted this project and I look forward to working with you again. Thanks also to Fred Vallance-Jones at the University of King's College who first piqued my interest in mental health. And to the late Dr. Darren Hynes from Memorial University who helped set me on this path.

My warmest love and appreciation go to of my partner Taylor Conrad who has been in my corner since the day we met. You have been doing the heavy lifting at home for the past few months, and I cannot express how much I cherish your friendship. I simply would not have finished this thesis without you. I must thank my dad Tom. Clearly your story telling has rubbed off on me, and your history lessons on our car rides to school first sparked my interest in this field. And to my mother, though I was not always the best student, you have always supported me in all of my post-secondary endeavours. Without you this project simply could not have come to fruition.

Finally, to my thesis committee, Dr. Peter Twohig, Dr. Kirrily Freeman, Dr. Leslie Digdon, and Dr. James Moran. I sincerely appreciate that each of you took time out of your busy schedules to help me in completing this thesis. The final version was significantly improved as a result of your comments, and any errors that remain are mine.

Alex Myrick

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Chapter I

Introduction

In recent decades, academic studies on the history of mental health and psychiatry have been popular within the broader historiography of health and medicine, especially in Canada. Since the 1960s, a diverse collection of authors have explored these topics, and many continue to approach the history of mental health and psychiatry through more critical, revisionist, neo-Whig, counter-revisionist, and mixed methodologies.[1] This has produced a varied literature where new texts add to the historiography's profound complexity by persistently challenging past perceptions of mental health and psychiatry's history. As a result of this deep level of interest, the field has become crowded with scholars who focus their investigations on specific facets of this broader subject matter. Popular topics have included institutional and asylum hierarchies, the development of psychiatry and psychiatric research, psychosurgery, the evolution of psychopharmaceuticals, and the recent period of deinstitutionalization as well as many sweeping examinations of mental health throughout extended periods of history.[2] Most

[1] Ludmilla Jordanova, *History In Practice*, 2nd edn (London: Hodder Education, Hachette Livre UK, 2006), 75; Thomas E. Brown, "Dance of the Dialectic? Some Reflections (Polemic and Otherwise) on the Present State of Nineteenth-Century Asylum Studies," *Canadian Bulletin of Medical History* 11 (1994): 267-268; James Moran, *Committed to the State Asylum: Insanity and Society in Nineteenth-century Quebec and Ontario* (Montreal: McGill-Queens University Press, 2000), 6-12.

[2] S. E. D. Shortt, *Victorian Lunacy: Richard M. Bucke and the practice of late nineteenth-century psychiatry* (Cambridge: Cambridge University Press, 1986), 1-162; Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997), 1-327; Jack David Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (Cambridge, U.K.; New York, NY: Cambridge University Press, 1998), 1-442; David Healy, *The Creation of Psychopharmacology* (Cambridge: Harvard University Press, 2002), 1-469; Judith Fingard and John Rutherford, "Deinstitutionalization and Vocational Rehabilitation for Mental Health Consumers in Nova Scotia since the 1950s," *Histoire sociale/Social history* 44:88 (Novembre-November 2011): 385-408; Ian Dowbiggin, *The Quest for Mental Health: A tale of science, medicine, scandal, sorrow, and mass society* (New York: Cambridge University Press, 2011), 1-248.

recently there has been a surge in publications that examine patient and advocacy perspectives and these have helped to identify many long neglected aspects from within mental health and psychiatry.[3]

As historians continue to analyze this field, some have begun to scrutinize the ways in which psychiatry interacted with other medical disciplines and health care institutions in the twentieth century. These authors have noted that during this era, psychiatry further integrated into general hospitals and medical schools as the discipline reoriented itself in ways that made psychiatry more influential in society.[4] In this sense psychiatry became normalized within medicine as medical school curricula began to include more instruction in psychiatry, and as the specialty was incorporated into general hospitals through both inpatient wards and outpatient clinics. Subsequently patient care was organized in new ways which required psychiatrists, physicians, and other health care professionals to work together so as to heal both the physically and mentally ill.[5] In light of these dramatic

[3] David MacLennan, "Beyond the Asylum: Professionalization and the mental hygiene movement in Canada, 1914-1928," *Canadian Bulletin of Medical History* 4 (Spring 1987): 7-23; Megan J. Davies, *The Patients' World: British Columbia's Mental Health Facilities, 1910-1935*, (M.A. Thesis, Department of History, University of Waterloo, 1989); Geoffrey Reaume, *Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870-1940* (Toronto: University of Toronto Press, 2009), 1-462; Judith Fingard and John Rutherford, *Protect, Befriend, Respect: Nova Scotia's Mental Health Movement 1908-2008* (Black Point, Nova Scotia: Fernwood Publishing, 2008), 1-157.

[4] James Walkup, "The Psychiatric Unit Comes to the General Hospital, A History of the Movement," *New Direction For Mental Health Services* 73 (Spring 1997): 11-23; Arthur H. Aufses and Barbara J. Niss, *This House of Noble Deeds, The Mount Sinai Hospital, 1852-2002* (New York: New York University Press, 2002), 316-332; Tara H. Abraham, "Psychiatry in American Medical Education, The Case of Harvard's Medical School, 1900-1945," *Canadian Bulletin of Medical History* 35:1 (Spring 2018): 63-93; Pressman, *Last Resort*, 29-30; Gerald Grob, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton: Princeton University Press, 1991), 30-32.

[5] Adolf Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer, Fifty-Two Selected Papers, Edited with Biographical Narrative by Alfred Lief* (New York, Toronto, McGraw-Hill Book Company, McGraw-Hill Series in Health Science, 1948), x-xii; DUA Jones, MS 13 14, Box 51, Folder 25, (1939-41), Robert O. Jones papers Supplement 1, Personal Papers, Adolf Meyer at Johns Hopkins, Adolf Meyer, "How Can Our State Hospitals Promote A Practical Interest In Psychiatry Among The Practitioners?" *Reprint from "State Hospitals Bulletin" for May 1908* (Utica, N.Y.: State Hospitals Press, 1908): 1-12; Dowbiggin, *The Quest for Mental Health*, 141.

changes, psychiatric normalization must be recognized as one of the most important aspect of psychiatry's twentieth century reformation which both propelled the specialty into the medical mainstream and gave it a greater position of authority within the medical community and society. Although some scholars have already written about the integration of psychiatry into medical schools and general hospitals, these studies have only briefly considered the intellectual basis of psychiatric normalization. If this broad concept is to be properly understood, then an assessment of the leading intellectuals in the field and their reform ideas must be accomplished. Understanding the circulation of ideas which supported psychiatry's integration into the wider medical community helps us to grasp the process of psychiatry's normalization within medicine. Finally, understanding these ideas also helps to elucidate the institutional and infrastructural revolution which took place in psychiatry between 1900 and 1970.

With these issues in mind, the objective of this thesis is to provide an analysis of the intellectual history of psychiatry and the ideas which facilitated the normalization of psychiatry. Dr. Adolf Meyer and his theory of psychobiology is critical to the transformation of North American psychiatry in the twentieth century. When Meyer arrived in America in 1893, he found a specialty that was scientifically and geographically isolated from the rest of medicine. Furthermore, asylums were overcrowded, and therapeutic pessimism consumed in the profession. Meyer quickly built a reputation as the United State' foremost reformer of psychiatry as he restructured the specialty into a "clinical science of psychiatry." In 1908, Meyer was hired as the chief of psychiatry at Johns Hopkins University, America's leading medical school. This made Meyer the most influential psychiatrist on the continent, and from this position he spread his theoretical,

treatment, and reform ideas throughout the United States and Canada. Meyer published articles in many of the top medical and psychiatric journals which helped to spark a wider interest in his ideas amongst physicians and psychiatrists. At Johns Hopkins, Meyer also passed his ideas and methods on to new psychiatry students as well as general practitioners and specialists.[6] As these ideas moved throughout the medical community, they led to reforms that created a new environment in psychiatry. The consequences of these reforms were that psychiatry became more scientific while the specialty assumed a greater role in the management and prevention of mental illness in society. Over time, the Meyerian approach came to dominate the discipline and other physicians realized that psychiatry was a valuable medical specialty.[7] Ultimately by 1970 these reforms allowed psychiatry to gain space within medical schools and general hospitals, and the specialty normalized within somatic medicine. In assessing this process in North America, it becomes clear that the intellectual foundation of psychiatric normalization was built upon the ideas of Adolf Meyer.

To support this argument, a review of relevant international, Canadian, and Nova Scotian writing on the history of psychiatry is necessary. Situating the study in this way will demonstrate that there has been a lack of scholarly attention given to psychiatric normalization. Secondly, to comprehend why normalization occurred in the twentieth century it is imperative to understand the medical ideas and health care infrastructures which existed in the preceding centuries. Consequently, this thesis must consider how the somatic and psychiatric branches of medicine evolved since the late-eighteenth century

[6] S. D. Lamb, *Pathologist of the Mind: Adolf Meyer and the Origins of American Psychiatry* (Baltimore: Johns Hopkins University Press, 2014), 2, 27, 253-254.
[7] Lamb, *Pathologist of the Mind*, 2-3.

when mind-body dualism influenced the development of asylums and moral therapy for the mentally ill and general hospitals for the physically ill. By assessing the early development of psychiatric medicine, it will be shown here how asylums grew overcrowded and care became custodial as the specialty found itself more scientifically, geographically, and professionally isolated from other fields of medicine towards the end of the nineteenth century. It is this context that Meyer sought to address. The significant concepts which he introduced to North America include psychobiology, psychiatry as a medical science, and the medicalization of mental illness, as well as adding psychiatric services to general hospitals through inpatient wards, outpatient clinics, and community clinics. Meyer also improved psychiatric education in university medical schools, and he helped found the mental hygiene movement. These ideas comprise the major aspects of his reform strategy, and each led to psychiatry's normalization within somatic medicine.

Analysing such ideas in detail highlights Meyer's place in the history of North American psychiatry as its principal reformer. This thesis will also consider the ways in which these ideas influenced the growth of psychiatry in the twentieth century since his theories and reforms helped to decisively overturn moral therapy. Additionally, these ideas changed the relationships that existed between psychiatrists and other physicians as psychiatric wards and clinics increasingly opened in general hospitals. Finally, this thesis assesses the impact of Meyer's ideas in Nova Scotia. It will be demonstrated that reforms in the province occurred in tandem with those that transpired elsewhere in the country, and Nova Scotia became an inventive leader within Canadian psychiatry by the latter half of the century. Nova Scotia is used as a case study that provides insight into the ways Meyerian psychiatrists such as Robert O. Jones, turned Meyer's reform ideas into institutional and

infrastructural realities. As these reforms occurred throughout the province, the existing boundaries between psychiatry and other medical specialties were dissolved. With Meyer's broad strategy being achieved in Nova Scotia, psychiatry integrated into mainstream medicine by the 1970s. The larger aim here is to establish that across North America psychiatry normalized within somatic medicine between 1900 and 1970. The ideas which allowed for this process to unfold all derive from Adolf Meyer whose theory of psychobiology upended mind-body dualism in medicine and forced a transformation in treatment methods and infrastructures in mental health care.

Through primary source research it was determined that Adolf Meyer and other psychiatrists were most involved in developing, circulating, and applying these reform ideas. Because of these findings, Meyer, his department and clinic, as well as medical journals, and the archival collections of Nova Scotian psychiatrist Robert O. Jones are used throughout this thesis. When viewed independently, Meyer must be seen as the intellectual point of origin for many of these reform ideas in North America. The Phipps Clinic and Meyer's program at Johns Hopkins were crucial in this process as they became the models upon which other medical school psychiatry curriculums and mental health infrastructures were based. Publications such as the *American Journal of Psychiatry* (*AJP*) and the *Journal of the American Medical Association* (*JAMA*) played an important role in psychiatry's normalization as they were the essential knowledge transfer venues used by psychiatrists to discuss and disseminate these reforms within the medical community. Jones meanwhile personifies the Meyerian student, and he is used as an exemplar who demonstrates how Meyer's curriculum, theories, and reform ideas were passed to his pupils. Upon graduation, students such as Jones returned from Johns Hopkins with those reform ideas infused into

their approach to psychiatry. Once in Halifax, Jones was in a position to use psychobiology in his own practice, and to initiate the reform ideas he learned from Meyer. Viewed in total, from Meyer, his curriculum and the Phipps Clinic, to the medical journals, and Jones, together these aspects and characters exemplify the route that Meyer's psychiatric ideas travelled from their source to their regional conclusion in Nova Scotia.[8]

The Historiography of Mental Health, Psychiatry, and Medicine in North America

For decades, prominent scholars have written on the history of mental health and psychiatry, making this historiographical field highly distinguished today. Amongst the array of topics, asylums have been analysed most, with psychiatry, eugenics, and especially deinstitutionalization, as well as patient and advocacy perspectives garnering more attention in recent years. Surprisingly within this rich historiography, the intellectual roots of psychiatry's normalization have been given little consideration by historians. Writing in 1994, Thomas E. Brown dissects the historiographical debates on asylums and highlights the shift from Whig histories towards revisionist narratives and a "third way," or a counter-revisionist paradigm grounded in the precepts of the "new social history."[9] Brown states that the field was once dominated by the "march of progress" perspective which focused on great psychiatrists, their books, discoveries, and triumphs. Yet for Brown, the history of

[8] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 357; Frank W. Stahnisch and Marja Verhoef, "The Flexner Report of 1910 and Its Impact of Complementary and Alternative Medicine and Psychiatry in North America in the 20th Century," *Evidence-Based Complementary and Alternative Medicine* 2012 (2012): 1, 2, 5; Pressman, *Last Resort*, 30-34, 43-44; DUA Jones, Jones, MS 13 14, Box 47, Folder 19, Victoria General – Residents - Teaching Materials - Psychiatry and Education (Adolf Meyer) (n.d.), Robert O. Jones, *Psychiatry And Education*, (1957): 4.

[9] Brown, "Dance of the Dialectic?", 268; Nancy Tomes, *The Art of Asylum-Keeping*: *Thomas Story Kirkbride and the Origins of American Psychiatry* (Philadelphia: University of Pennsylvania Press, 1994), 7-11.

psychiatry was "a stagnant intellectual backwater."[10] In the 1960s and 1970s, three texts were published that led the way towards a "new history" movement. These were Michel Foucault's *Madness and Civilization* published in 1961, David Rothman's *The Discovery of the Asylum* from 1971, and Andrew Scull's *Museums of Madness* published in 1979. Brown argues that each text opposed the "long-accepted "Whiggish" view" of the asylum as a "noble humanitarian reform."[11] Instead, these authors developed the "social-control" theory which stipulates that since the Enlightenment, western society used asylums as a way to oppress and confine people who were seen as a threat to the established order. Through these revisionist approaches other historians began to reinterpret many long-held narratives in medical history.[12]

Brown explains that these works were criticized at the time, and the social-control school held only a fleeting monopoly.[13] With historian Gerald Grob's 1973 book *Mental Institutions in America*, a "neo-whig" approach sprang up and debates ensued over the efficacy of social-control. Grob also suggests that scholars were confined to two perspectives. One saw the asylum as a "gigantic moral imprisonment" and the other argued they were a "triumph of scientific and humanitarian zeal."[14] This "treatment-incarceration dichotomy," Grob argues, pushed the field in a stultifying direction. In 1984, historian Nancy Tomes recognized this problem when she wrote *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840-1883*. Tomes aimed to write a

[10] Brown, "Dance of the Dialectic?", 269.
[11] Brown, "Dance of the Dialectic?", 269.
[12] Jordanova, *History In Practice*, 77.
[13] Brown, "Dance of the Dialectic?", 268-271.
[14] Gerald Grob, "Reflections on the History of Social Policy in America," *Reviews in American History* 7:3 (September 1979): 293-306; Gerald Grob, "Rediscovering Asylums: The Unhistorical History of the Mental Hospital," *The Hastings Center Report* 7:4 (August 1977): 33-41; as cited in Tomes, *The Art of Asylum-Keeping*, 12.

"balanced account of the nineteenth-century asylum."[15] Following her lead, other historians realized the field was stuck in this dichotomy and they had been ignoring important aspects of asylum history. Many now endeavored to compose "detailed" archival studies which added to the understanding of asylums, psychiatrists, and other facets of nineteenth century mental health care.

On the other hand, Brown stresses that historians who embraced the "new social history" or the counter-revisionist approach, sought refuge in the "safe harbour of empiricism and objectivity" in an effort to avoid any assessment of theory and the "heavy seas of the present postmodernist storm."[16] Many scholars such as James Moran saw Brown's article as a "clarion call" for historians "not to ignore the theoretical and historiographical contributions of their revisionist predecessors." Commenting on the state of the field in 2000, Moran explains "the history of asylum studies is coming full circle."[17] Authors today are free to write in a revisionist manner where the "relationships between responses to insanity and the wider society, economic, and political contexts" are examined.[18] Others assume "neo-whig," "meliorist," or "semiapologetic" perspectives which try to account for those social, economic, and political contexts, while asserting that in the history of psychiatry, asylums, and mental health, there are blemishes which cannot be overlooked, but that progress has undoubtedly occurred and these advances should not be discounted. Today, some scholars still write in a counter-revisionist approach, while others feel they are not beholden to any historiographical tradition. Many historians use

[15] Brown, "Dance of the Dialectic?", 273.
[16] Brown, "Dance of the Dialectic?", 273-274.
[17] Moran, *Committed to the State Asylum,* 11.
[18] Moran, *Committed to the State Asylum,* 10.

whichever tools or perspectives help them in crafting their historical accounts. For example, Moran combines an "appreciation" for revisionists with "the methodological and analytical innovations of the new social historians of insanity and the asylum" as this fusion provides for a more "contextualized" history of the asylum.[19] As these developments have unfolded, contemporary American, Canadian, and Nova Scotian studies of mental health and psychiatry have grown plentiful with intriguing new narratives on asylums, deinstitutionalization, patient and advocacy perspectives, and individual psychiatrists, as well as many other subjects.

On the topic of American psychiatry, some historians have attempted to resurrect Adolf Meyer and his legacy.[20] Susan Lamb has recently argued that Meyer left a permanent and positive mark on the specialty. As she focuses on Meyer's career between 1892 and 1917, Lamb insists that he turned American psychiatry into a clinical science "that harmonized the practices and expectations of scientific medicine with his biological conception of mental illness."[21] Lamb also shows the ways in which Meyer developed his ideas in relation to the medical and scientific conditions that existed within psychiatry in the late- nineteenth and early- twentieth centuries. She presents her argument as a closely focused study on the workings of the Phipps Clinic and the ways in which Meyer developed and brought these theoretical and therapeutic ideas into his practice and curriculum. Within the historiography, Lamb implements a mixed approach which uses Meyer's archival materials to create a narrative that "revolves around the methods and

[19] Moran, *Committed to the State Asylum,* 6-12; Shorter, *A History of Psychiatry*, viii.
[20] Pressman, *Last Resort*, 18-46; Jack D. Pressman, "Essay Review: Psychiatry and Its Origins," *Bulletin of the History of Medicine* 71:1 (Spring 1997): 129-139.
[21] Lamb, *Pathologist of the Mind*, 3

concepts that Meyer devised in order to study and treat abnormal mental phenomena, or psychopathology."[22] Lamb's work positions Meyer in a way that assures his recognition as one of the preeminent figures in the history of psychiatry, one who enriched the specialty in the twentieth century. Lamb also addresses many of the reforms which Meyer spread across the continent, but since the book assesses a limited time frame, her work does not concentrate on the wider dispersal of his ideas and how they facilitated psychiatry's normalization.[23]

While psychiatric normalization remains generally unobserved throughout much of this literature, there are a few articles that specifically examine the specialty and its integration into general hospitals and medical schools. In 1997 clinical psychologist James Walkup, wrote "The Psychiatric Unit Comes to the General Hospitals, A History of the Movement," in which he argues that early twentieth century general hospitals were void of psychiatric units, but by the late 1980s "the majority of inpatient episodes" occurred in general hospital wards. For Walkup, general hospitals becoming the centre for acute psychiatric care "is arguably the most dramatic institutional change in psychiatry" since the development of the asylum. According to the author, this shift has received far less scholarly attention than the rise of psychoanalysis, deinstitutionalization, or community care. As Walkup explains, this shift was based upon the ideas of an older generation of psychiatrists who wanted to move psychiatric care away from asylums just as general hospitals were taking their "modern form," and work within these facilities "became worth coveting."[24] Over time, Walkup describes how more psychiatric units opened in general

[22] Lamb, *Pathologist of the Mind*, 10.
[23] Lamb, *Pathologist of the Mind*, 3, 9-10.
[24] Walkup, "The Psychiatric Unit Comes to the General Hospital", 13.

hospitals after psychiatrists in World War II recognized that "short term, recuperative models of care" were successful in treating soldiers.[25] Historiographically, Walkup follows a mixed approach which emphasizes the improvements general hospitals brought to patient treatment, but that these wards were now marked as economically inefficient in the 1990s.[26] Seen through an intellectual history perspective, though Walkup credits Meyer as being a leader in the field during the first half of the century, he overlooks the more fundamental theoretical changes that occurred within psychiatry, and how the circulation of Meyerian ideas laid the groundwork for this wider therapeutic, institutional and infrastructural shift.

In 2018, historian Tara Abraham published the article "Psychiatry in American Medical Education, The Case of Harvard's Medical School, 1900-1945." Through an analysis of archival material from Harvard, Abraham writes that psychiatrists "began to forge new professional identities in interwar America," and slowly psychiatry was recognized as a formal medical specialty. Regarding psychiatric integration into somatic medicine, Abraham asserts that "two related developments" catapulted psychiatry clear of its medical irrelevancy. First, psychiatry acquired a "presence within medical school curricula."[27] Secondly, psychiatry formed "complex and sometimes contentious interactions with neurologists and neuropathologists."[28] In both instances, psychiatry began to frame itself as a regular somatic specialty, and this made other disciplines more receptive to it. Together these developments brought psychiatry into Harvard Medical School over the course of the century's first half. In this article Abraham adopts a mixed methodology

[25] Walkup, "The Psychiatric Unit Comes to the General Hospital", 11.
[26] Walkup, "The Psychiatric Unit Comes to the General Hospital", 11-17.
[27] Abraham, "Psychiatry in American Medical Education", 63.
[28] Abraham, "Psychiatry in American Medical Education", 65.

which shows that psychiatry improved its professional status by 1945, while also demonstrating that Meyerian concepts influenced important medical institutions such as Harvard Medical School.[29] However, if the full extent of psychiatric normalization is to be understood then Meyer's theoretical ideas, his approach to treatment, and his reform strategy must be assessed more broadly and in greater depth.

The revisionist, neo-whig, counter-revisionist, and mixed methodologies can all be observed within the Canadian historiography as well. For instance, in the edited collection *Medicine in Canadian Society: Historical Perspectives* published in 1981, historian S. E. D. Shortt writes that much of the early literature by "elderly doctors" who were "innocent of the severe disciplines of history" adopted a Whig approach.[30] These accounts were seemingly written only to be read by other physicians, and many were a chronological listing of medical achievements. Shortt mentions several foundational Canadian texts written in this style: William Canniff's *The Medical Profession in Upper Canada, 1783-1850* (1894), W. B. Howell's *Medicine in Canada* (1933), and H. E. MacDermot's *One Hundred Years of Medicine in Canada, 1867-1967* (1967). Shortt clarifies that their primary concerns were with "the development of the profession, institutional growth, or progress in the understanding of major diseases," and they made little effort to examine the wider societal impact of medicine on Canadian society.[31] He also notes that both the Canadian and American historiography share many of the same trends and patterns. By the late 1960s and 1970s authors such as Robert E. McKechnie and T. F. Rose were trying to

[29] Abraham, "Psychiatry in American Medical Education", 63-66.
[30] S. E. D. Shortt, "Antiquarians and Amateurs: Reflections on the Writing of Medical History in Canada," in *Medicine in Canadian Society: Historical Perspectives*, ed., S. E. D. Shortt (Montreal: McGill-Queen's University Press, 1981), 2.
[31] Shortt, "Antiquarians and Amateurs," 6.

link the history of medicine to general social history. With Shortt's collection, he asserted that the time had come for medical and social historians to unite in exploring "more fully the Canadian medical past."[32] Shortt's own contribution to this effort examines asylum superintendent Richard M. Bucke. According to Shortt, Bucke "provides the superstructure for an analysis of major themes in late nineteenth-century Anglo-American psychiatry" as he "typified a generation of Victorian psychiatrists."[33] Bucke held prominent positions but was by no means "a figure of towering authority in his discipline" and was ostensibly devoid of originality. Despite his faults, Bucke published a substantial body of work and "may be portrayed by the historian as a foil."[34] Shortt's subject allows for a greater depth of knowledge to be discovered about the "contemporaneous psychiatric consensus."[35] His purpose therefore is to use Bucke to examine the "nature and genesis of late nineteenth-century psychiatry."[36] Shortt follows in the revisionist tradition, first by exploring a unique yet ordinary figure who gives perspective into the declining state of Canadian psychiatry in the late- nineteenth century. The author also uses a multidimensional approach that examines physicians, institutional characters, dominant social values, and explicit professional goals which all combined to "determine the nature of late-Victorian psychiatry."[37] While the product of Shortt's research added new layers of insight into psychiatry's history, the book does not address the normalization of the discipline within somatic medicine. This is understandable as Shortt only reviews the late-Victorian era, and the period of general hospital integration could not be part of his study.

[32] Shortt, "Antiquarians and Amateurs," 12.
[33] Shortt, *Victorian lunacy*, 2.
[34] Shortt, *Victorian lunacy*, 2.
[35] Shortt, *Victorian lunacy*, 2.
[36] Shortt, *Victorian lunacy*, 3.
[37] Shortt, *Victorian lunacy*, 3.

Following Shortt, other Canadian scholars have written on the history of psychiatry and mental health since the 1990s through revisionist, neo-whig, counter-revisionist, and mixed approaches. In 1997, Ian Dowbiggin wrote *Keeping America Sane: Psychiatry and Eugenics in the United States and Canada, 1880-1940*. This book follows a neo-whig or semiapologetic methodology which contends that in North America, psychiatrists latched on to the eugenics movement because degeneration explained why they could offer no cure for chronic mental illness, and because eugenics bolstered their professional status and allowed them to escape asylum work.[38] Another Canadian author, James Moran, uses a combination of a revisionist and family-oriented approach in his book *Committed to the State Asylum: Insanity and Society in Nineteenth-century Quebec and Ontario*. Moran traces "the social history of the lunatic asylum" as they developed in Ontario and Quebec. He demonstrates that asylums were influenced by the "interactions of people from a hierarchy of social and economic circumstances" from government inspectors to patient families. Within these hierarchies, all parties faced unequal power dynamics with government officials and asylum superintendents often exerting authority over patients and families. In certain contexts, however, families, neighbors, and communities were able to shape Canadian asylums as they controlled when a patient would be committed.[39] Historian Geoffrey Reaume built upon this revisionist and patient-oriented approach in *Remembrances of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870-1940*. Reaume focuses on the people who resided within this facility during the height of the asylum era in order to depict "the lives of people who were psychiatric patients long

[38] Ian Dowbiggin, *Keeping America Sane: Psychiatry and Eugenics in the United States and Canada, 1880-1940* (Ithaca, N.Y.: Cornell University Press, 1997), ix.
[39] Moran, *Committed to the State Asylum*, 9-12, 115-116.

ago."[40] His intent is to give a voice to those individuals who have been considered as "silent."[41] Reaume rightly focuses on the abuse patients suffered, but also illustrates that many were able to find agency within the asylum as they crafted their own unique lives.[42] None of these works directly address the idea of psychiatric normalization, but all provide evidence on the ways in which psychiatric treatment changed between the late- nineteenth and early- twentieth centuries when moral therapy fell out of favor.

In their recent book *Managing Madness: Weyburn Mental Hospital and the Transformation of Psychiatric Care in Canada*, authors Erika Dyck and Alex Deighton analyse this institution through a social history perspective. The duo also uses a multi-faceted approach which examines the cultural, political, economic, medical, and scientific aspects of patient care and psychiatry as they existed at Weyburn. Their main purpose is to analyze the legal, cultural, and medical ideas that form the Canadian notion of citizenship as it relates to the mentally ill, while also arguing that the stigma surrounding mental illness is an enduring problem.[43] Within the historiographical trends, Dyck and Deighton's work is a compelling example of how past approaches can be combined into a mixed methodology which clarifies numerous issues in the history of mental health and psychiatry. The initial divisions between psychiatry and somatic medicine are not discussed, but aspects of psychiatric normalization are slowly revealed as Dyck and Deighton explain that more medical schools developed psychiatry departments while general hospitals opened

[40] Reaume, *Remembrance of Patients Past*, xi.
[41] Reaume, *Remembrance of Patients Past*, 3.
[42] Reaume, *Remembrance of Patients Past*, 21, 38-41, 81, 99.
[43] Erika Dyck and Alex Deighton, *Managing Madness: Weyburn Mental Hospital and the Transformation of Psychiatric Care in Canada* (Winnipeg: University of Manitoba Press, 2017), 1-32.

psychiatric wards and outpatient clinics as the transition towards deinstitutionalization unfolded.[44]

In Nova Scotia, historian Judith Fingard and co-author John Rutherford contributed the chapter "Social Disintegration, Problem Pregnancies, Civilian Disasters: Psychiatric Research in Nova Scotia in the 1950s" to an edited collection assembled by James Moran and David Wright in 2006. The authors affirm that Nova Scotia was a hub for innovative psychiatric research after World War II, and they present the Springhill Mine Disaster Studies, the Spontaneous Abortion Study, and the Stirling County Study as evidence. This chapter fits within the Canadian historiographical trends as Fingard and Rutherford employ a social history approach with mixed methodological features. This aids the authors in emphasizing that a confluence of factors consisting of psychology's professional split with psychiatry, a declining interest from the provincial government in funding psychiatric research, and the increasing pressure of clinical services in psychiatry, all led to a downturn in Nova Scotian psychiatric research by the 1960s. Yet as the authors illustrate, these projects highlight the interconnectivity that existed between psychiatrists, other physicians and mental health care workers at this time. The bond between Jones and Harold "Benge" Atlee provides one example of an obstetrician and gynecologist forming a close professional relationship with a psychiatrist. Furthermore, with regards to psychiatric normalization, the Spontaneous Abortion Study on which Jones and Atlee worked together shows how psychiatry was brought closer to a "more commonly experienced, and therefore

[44] Dyck, Deighton, *Managing Madness*, 35-36, 107, 138-140, 166-167, 176, 184, 191.

better accepted" medical specialty, and that this may have legitimized psychiatry within somatic medicine.[45]

Another significant text from Fingard and Rutherford is *Protect, Befriend, Respect: Nova Scotia's Mental Health Movement 1908–2008*. This history of mental health advocacy in the provinces fits well within the developing Canadian historiography which now includes more patient-oriented perspectives. The pair illustrate that the Canadian Mental Health Association (CMHA) and its provincial forerunners altered mental health care in Nova Scotia by establishing cooperative relationships with "local governments."[46] *Protect, Befriend, Respect* also presents the most prominent mental health activists, psychiatrists, and government officials who reshaped the province's mental health care system. Moreover, emphasizes patient-perspective history because it describes how the Nova Scotian branch of the CMHA was originally led by psychiatrists, but by the latter half of the century mental health consumers assumed leadership roles. This dramatically influenced the objectives of the association which now aimed to empower consumers "to speak for themselves."[47] Additionally, with its partial focus on the development of psychiatry and the mental health care system, this work provides insight into the normalization of psychiatry. For example, advocates in the 1930s called for a psychiatry department to be established at Halifax's Victoria General Hospital, and by the 1960s, psychiatrists argued that their patients "could be more appropriately integrated into general

[45] Judith Fingard and John Rutherford, "Social Disintegration, Problem Pregnancies, Civilian Disasters: Psychiatric Research in Nova Scotia in the 1950s," in *Mental Health and Canadian Society: Historical Perspectives*, eds., James E. Moran and David Wright (Montreal: McGill-Queen's University Press, 2006), 204-212.
[46] Fingard, Rutherford, *Protect, Befriend, Respect*, ix.
[47] Fingard, Rutherford, *Protect, Befriend, Respect*, 20-43, 126-139.

medical wards."[48] These details make Fingard and Rutherford's work an essential text both within the evolution of this wider historiography, and as a source which sheds light on the growth of psychiatry in Nova Scotia.

Remarkably the progressive tradition is not entirely extinct. In his book *Noble Goals, Dedicated Doctors: The Story of Dalhousie Medical School*, author T. Jock Murray focuses on the major developments in medicine as they were experienced at this institution. Murray, a former Dean of Medicine at Dalhousie, assesses the past 150 years of the school's history. The book refers to key figures such as Sir Charles Tupper, James DeWolf, and William Harrop Hattie, among many others. It is crucial, however, to mention the book's greatest shortcoming, which is that it lacks an historical argument. Murray presents a conventional progressive and chronological record of the medical school. When compared to other texts in the historiography, Murray's work is proof that the Whiggish approach is still active within the contemporary literature. Murray does describe how psychiatrists interacted with the University, and how the discipline became part of the medical school, but there is no critical assessment of the normalization process. Murray only explains that Dalhousie had to catch up to developments in psychiatry that were going on elsewhere. The deeper arguments that would have occurred between different specialists before psychiatry became an official department at the university are not assessed.[49]

These texts exemplify the many methodological approaches historians and other scholars have used when assessing the history of mental health, psychiatry, and medicine. Each work reveals that authors have adopted these methodologies to investigate subjects

[48] Fingard, Rutherford, *Protect, Befriend, Respect*, 36, 18.
[49] T. Jock Murray, *Noble Goals, Dedicated Doctors: The Story of Dalhousie Medical School* (Halifax: Nimbus Publishing, 2017), 4-16, 126, 243-245.

such as individual psychiatrists in the United States, as well as changes in American mental health care infrastructures and medical school curriculums. The approaches which shaped the historiography in the American field were also observed as the same trends transpired in Canada. Individual psychiatrists have been analysed by Canadian historians, and a range of scholars have written on other topics related to mental health and psychiatric history from a variety of perspectives. Finally, Nova Scotian examples were noted as authors in the province have employed mixed methodologies while others still write in the progressive or "Whig" fashion. It was discerned that scholars have not examined psychiatric normalization as the topic has yet to garner much attention within the historiography. In the ensuing chapters, this thesis will investigate psychiatric normalization and the evidence considered here will prove that this process was the intellectual progeny of Adolf Meyer. As his theories, ideas, and reforms circulated throughout the North American psychiatric and medical community, they helped to cultivate a landscape in which major reforms in mental and somatic medicine could transpire between 1900 and 1970. With the spread of these reform ideas, psychiatry was placed in a position where it could be normalized within general somatic medicine.

Chapter II

Psychiatry's Separation from Somatic Medicine and its Decline by the 1890s

To perceive how psychiatry normalized within mainstream medicine in the twentieth century, it is necessary to first consider the ways in which care was structured differently for the mentally and the physically ill. The purpose of this chapter is to distinguish between the origins of the asylum and the general hospital, and to chart the development of psychiatric medicine since the late- eighteenth century. To accomplish this objective the philosophical and medical theory of mind-body dualism must be examined, as well as the reasoning of early psychiatrists and somatic physicians which specified that the mentally ill should be sent to asylums and that an entirely distinct therapeutic approach known as moral therapy should be used to heal them. Next, the trajectory of psychiatric medicine over the nineteenth century will also be evaluated. It is equally important to consider that as asylums expanded across North America, so too did general hospitals. By the 1890s however, these institutions had turned into scientific "temples of healing" and the reputation of somatic medicine rose.[1] Psychiatrists meanwhile found themselves in the midst of an unprecedented professional calamity as asylums swelled with chronic and incurable patients, superintendents grew increasingly bureaucratic, and care became custodial rather than curative. Therapeutic pessimism swept through the field as a result, and the specialty's scientific and geographic isolation from other aspects of medicine was

[1] Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987), 245.

only exacerbated by the end of the century.[2] It will be shown here that the crisis in asylums forced psychiatry to initiate new reforms if the discipline was to survive.

Prior to the birth of the asylum, most people who suffered from mental illness were cared for at home by their families. Since madness in European culture was thought to be caused by demonic possession or "bad stock," mental illness brought shame upon a household. While some provided good living conditions for their loved one, other families were only able to restrain and confine the insane.[3] If a family could no longer afford to care for the person, or if their patience had worn too thin, then the mentally ill might be cast out on to the streets and left to fend for themselves. In other instances, they would be given over to the local jail which was an "unpredictable and chaotic environment," or they might find shelter in almshouses, workhouses, and poorhouses.[4] In larger cities, psychiatric hospitals, or madhouses had already been in existence since the early-fifteenth century. The most famous example, St. Mary of Bethlehem religious house, was founded in London in 1403. Over the years its name was colloquially shortened to Bethlem and then "Bedlam," now a synonym for madness itself. As historian Edward Shorter writes, these institutions had "solely custodial functions" as western society "had no notion of delivering therapy to patients" before the nineteenth century.[5] Furthermore, despite insanity being a common

[2] Dowbiggin, *Keeping America* Sane, 9, 59; Shortt, *Victorian Lunacy*, 36.
[3] Roy Porter, *Madness: A Brief History* (Oxford: New York: Oxford University Press, 2002), 89-90; Gerald N. Grob, "Review of a History of Psychiatry: From the Era of the Asylum to the Age of Prozac," *Bulletin of the History of Medicine* 72:1 (1998): 153-155.
[4] Barry Edginton, "Moral Architecture: The Influence of the York Retreat on Asylum Design," *Health and Place* 3:2 (1997): 91-92; Dora B. Weiner, "The Madman in the Light of Reason: Enlightenment Psychiatry: Part II. Alienists, Treatises, and the Psychologic Approach in the Era of Pinel," in *History of Psychiatry and Medical Psychology*, eds., E. R. Wallace and J. Gach (Boston, M.A.: Springer, 2008), 281; Shorter, A History of Psychiatry, 1-3; Moran, *Committed to the Asylum*, 4; Daniel Francis, "The Development of the Lunatic Asylum in the Maritime Provinces," *Acadiensis,* 6:2 (1977): 24.
[5] Shorter, *A History of Psychiatry*, 4.

ailment known to humanity since antiquity and doctors having written on the subject, a group of physicians specializing in mental illness did not yet exist.[6]

Before 1800, this lack of specialization was not unusual: distinct disciplines did not yet exist outside of surgery.[7] Moreover, the wider medical marketplace was an eclectic mix of practitioners who included orthodox physicians, apothecaries, clergymen, wise women, herbalists, and midwives as well as travelling drug pedlars, charlatans, swindlers, and quacks. The training and education, in addition to the therapeutic methods practiced by each group varied greatly, but with orthodox physicians, some were identifiable as being the only medical practitioners who were university graduates. By the eighteenth century, well-established systems of university medical education existed across most western nations such as France, Germany, and the United Kingdom. In the United States, the University of Pennsylvania School of Medicine was modelled on British institutions and opened in 1765.[8] Despite a precipitous increase in population after the 1790s, "the Canadas made virtually no provision for medical education"[9] until 1829 when the Montreal Medical Institution became the Medical Faculty of McGill College.[10]

Historian W. F. Bynum describes how, in these early medical schools, students were taught a range of subjects. For example, at Edinburgh, the renowned medical teacher William Cullen, whose writings were translated into other languages, taught chemistry,

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[6] Shorter, *A History of Psychiatry*, 1, 4-5.
[7] Shorter, *A History of Psychiatry*, 1.
[8] W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (New York: Cambridge University Press, 1994), 2-10.
[9] Joseph F. Kett, "American and Canadian Medical Institutions, 1800-1870," in *Medicine in Canadian Society: Historical Perspectives*, ed., S. E. D. Shortt, (Montreal: McGill-Queen's University Press, 1981), 196.
[10] Barbara R. Tunis, "Medical Licensing in Lower Canada: The Dispute over Canada's First Medical Degree," in *Medicine in Canadian Society: Historical Perspectives*, ed., S. E. D. Shortt, (Montreal: McGill-Queen's University Press, 1981), 141.

physiology, materia medica, pathology, and the practice of medicine. According to Cullen, medicine was the "art of preventing and of curing disease," and it was founded on three pillars, or "Institutions (or institutes) of Medicine." As Cullen defined them "the first treats life and health [physiology]. The second delivers the general doctrine of disease [pathology]. The third delivers the general doctrine concerning the means of preventing and curing diseases [therapeutics]."[11] Bynum also adds anatomy as a fourth pillar, which physicians in the eighteenth century argued was "necessary to understand the functions of the body in health and disease."[12] Earlier in the century Hermann Boerhaave suggested that blood and blood vessels were mainly responsible for disease, while Friedrich Hoffman argued that the nervous system was central to human health. Through new exploratory research in anatomy, the nervous system, and the cardiovascular system, physicians by the 1790s were beginning to understand health as it related to the body's physiological functions. Consequently, doctors were finally noticing problems with the humoral theory of medicine. This ancient Hippocratic concept specified that to maintain good health and to cure disease, the body's four humors of blood, black bile, yellow bile, and phlegm, had to be balanced.[13]

Despite these new ideas, most physicians in the eighteenth and much of the nineteenth century still tried to balance humors using tools to bleed, purge, blister, and "Clyster" their patients. This form of medical treatment has become known as "heroic medicine" and it was especially popular in the United States due to the writings of Benjamin Rush who advocated for the use of mercurous chloride (calomel) as a purgative.

[11] Bynum, *Science and the Practice of Medicine in the Nineteenth Century*, 11-12.
[12] Bynum, *Science and the Practice of Medicine in the Nineteenth Century*, 12.
[13] Bynum, *Science and the Practice of Medicine in the Nineteenth Century*, 10-15.

Although these treatments were popular amongst orthodox practitioners, patients themselves understandably grew hostile towards physicians by the nineteenth century. And regardless of the fact that a few medical schools were in operation, medical training throughout Europe and North America was still deficient. As Shorter makes clear, most physicians were trained through apprenticeships with older practitioners while medical schools taught a curriculum that lacked courses and lectures with hands-on experience at the patient's bedside. Heroic medicine together with poor standards in education gave most orthodox physicians a negative public image.[14]

Through this disjointed system of education and the emphasis on humoral therapy, it is clear that mental illness was a subject not taught to most physicians, and few knew how to treat such patients. As learning was achieved primarily through apprenticeships, psychiatry as a specialty first grew out of the early custodial institutions for the mentally ill. Throughout the eighteenth century at Bethlem in London, the Bicêtre in Paris, in central Europe's network of small regional asylums, almshouses, and jails, as well as in the Boston almshouse psychiatric ward, certain physicians were hired to manage the facilities where the mentally ill were housed. As Shorter explains, in 1751, William Battie was appointed as the founding medical officer at St. Luke's Hospital in London. In 1758, Battie published his *Treatise on Madness.* This was the first time a physician argued that asylums had therapeutic qualities, and that placing the mentally ill in an institution where they were confined and segregated could have a beneficial effect on their mental state. In quoting a colleague, Battie asserted that the management of the mentally ill was more beneficial to

[14] Edward Shorter, *Doctors and Their Patients: A Social History* (New Brunswick, N.J.: Transaction Publishers, 1991), 32-34.

their state of mind than the use of medicines. Experience had also convinced him that "confinement alone is oftentimes sufficient, but always so necessary that without it every method hitherto devised for the cure of madness would be ineffectual."[15]

In the ensuing decades other physicians found employment in these early asylums. For example, Vincenzio Chiarugi, took a position at the Santa Dorotea hospice in Florence in 1785. Shortly after his arrival, Chiarugi suggested to the Austrian Grand Duke Leopold, administrator of the province of Tuscany, that the mentally ill patients at Santa Dorotea, be moved to the old Banifazio hospital. Once this facility was renovated, Chiarugi moved his patients. He then established a set of regulations that were intended to maintain order, while he rejected custodialism, medications, and restraints in an effort to treat the "mad as human beings."[16] As Battie had argued, Chiarugi too was suggesting that institutionalization had the power to heal mental illness. This conceptual shift in physicians viewing the asylum as therapeutic brought with it the beginnings of a new medical specialization in asylum medicine, the precursor to psychiatry.

In 1791, a Quaker woman named Hannah Mills was diagnosed with melancholy. Shortly after her admission to the York asylum she was found dead. Her friends and family suspected that Mills may have been mistreated as the administrators denied her any visitors during her confinement. Upon hearing of the incident, prominent Quaker businessman William Tuke, guided by the ideals of his own religious morality, thought the conditions in asylums should be greatly improved and that a new, more restorative asylum should be constructed. To grasp what would be required in such an endeavor, Tuke toured St. Luke's.

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[15] William Battie, *A Treatise on Madness* (London: Whiston, 1758), 68-69; as cited in Shorter, *A History of Psychiatry*, 9-10.
[16] Shorter, *A History of Psychiatry*, 10; Roy Porter, *Madness*, 104.

During his visit, Tuke saw a young woman "naked and filthy, chained to a wall."[17] The living conditions for most patients were abhorrent, the quality of the medical care was abysmal, and many were often detained in mechanical restraints. Though Battie had proposed that asylum isolation was beneficial for the mentally ill, Tuke found the cruelty which the St. Luke's staff leveraged over their charges unacceptable.[18]

The next year, Tuke started building the York Retreat. When it opened in 1796, this version of the asylum was erected in a bucolic rural environment where patients lived in a communal setting patterned on the comforts of the English family home. Not only would confinement cure the mentally ill as Battie had theorized, but the mental health of patients was to be restored through the idyllic qualities of the institution itself. Tuke's therapeutic objective was to mend the patient by placing them within this relaxing backdrop and structuring their lives around disciplined routines. Staff ate, worked, and lived together on the premises with patients, and everyone was considered to be part of the same collective family. If patients obeyed the rules, worked hard, and followed the institution's routines they would be rewarded. Failing to meet these expectations, however, might result in a patient being reprimanded.[19]

The Retreat also differed from previous mental asylums in that patients were restrained only as a last resort, and treatments such as bleeding and purging were minimized.[20] Writing the *Description of the Retreat* in 1813, Tuke's grandson Samuel described how these procedures were initially performed, but the staff soon realized they

[17] Ayisha A. Kibria and Neil H. Metcalfe, "A biography of William Tuke (1732-1822): Founder of the modern mental asylum," *Journal of Medical Biography* 24:3 (2016): 385.
[18] Kibria, Metcalfe, "A biography of William Tuke," 384.
[19] Porter, *Madness*, 103-104.
[20] Dowbiggin, *The Quest for Mental Health*, 20.

did little to improve the mental health of the patient. As a result, Tuke developed a new treatment approach called "moral therapy," which specified that the mentally ill would be cared for through "kindness, mildness, reason, and humanity, all within a family atmosphere, and with excellent results."[21] The Tukes had added a new element to the notion of confinement being effective in curing mental illness. Moreover, as Dowbiggin explains, the guiding philosophy of the Retreat was "decidedly non-medical – if not overtly anti-medical."[22] The Tukes promoted a form of "psychological therapy mixed with rigorous expectations about how a "rational" person ought to think and behave."[23] In the soothing country environment of the Retreat, the patient would forget about the stresses of daily life at home. Simultaneously, the Retreat's familial structure, rules, and rigid routines ensured that each patient had to conform to the moral codes outlined by Tuke. These features were intended to appeal to the rational qualities Tuke felt were buried deep within each mentally ill patient, and over time they would be restored to their normal selves.[24]

Tuke was not the only one to pursue asylum reform during the late eighteenth century. On the European continent, the ideas of Genevan philosopher Jean Jacques Rousseau inspired political change in European society, but he also influenced medicine. As psychiatrist David Healy writes, Rousseau's *Social Contract* (1762) "articulated the political vision that lay at the heart of the Enlightenment."[25] Rousseau's ideas challenged "authoritarian, hierarchical, and patriarchal social arrangements," while he also argued that

[21] Porter, *Madness*, 104; Samuel Tuke, *Description of the Retreat, an Institution near York, for Insane Persons of the Society of Friends, Containing an Account of Its Origin and Progress, the Modes of Treatment, and a Statement of Cases*, Psychiatric Monograph Series 7 (London: Dawsons of Pall Mall, 1964), 71-83, 84-117.
[22] Dowbiggin, *The Quest for Mental Health*, 20.
[23] Dowbiggin, *The Quest for Mental Health*, 20.
[24] Dowbiggin, *The Quest for Mental Health*, 20.
[25] Healy, *The Creation of Psychopharmacology*, 334-335.

society's ills and individuals' discontent came from the pressures of urbanization which removed people from their traditional pastoral existence.[26] The solution to societal and personal unhappiness, as well as illness and disease, was to be found through therapeutic revolution and a return to "rural simplicity."[27] Whether in politics or medicine, followers of Rousseau began to suggest that the old order had to be overturned if people everywhere were to become free. Many in elite circles felt that the mentally ill who were literally chained and segregated from the rest of society required better treatment that would help them in regaining their rational qualities.[28]

This combination of ideas rose in popularity, especially in late eighteenth-century France where they inspired the Revolution in 1789.[29] Following the assassination of Jean-Paul Marat in 1793, the Jacobin government requested that Dr. Phillipe Pinel take charge of the Salpêtrière and Bicêtre Hospitals in Paris. In the history of psychiatry, Pinel is of particular importance. Battie argued that confinement was therapeutic, Chiarugi practiced non-restraint, and the Tukes used religious morality to guide their treatment at the York Retreat. Yet it was Pinel who devised methods of treating and comprehending mental illness through a new psychological approach. According to historian Roy Porter, many of the medical texts at the time favored untested abstract theories and heroic remedies for treating insanity. Pinel instead opted first to observe patients. He soon found that restraints were useless in curing insanity because troubles of the mind could only be treated by engaging with the mind and by appealing to the rational faculties of the person. Through

[26] Healy, *The Creation of Psychopharmacology*, 335.
[27] Bynum, *Science and the Practice of Medicine in the Nineteenth Century*, 64; Healy, *The Creation of Psychopharmacology*, 334-335; Dowbiggin, *The Quest for Mental Health*, 12.
[28] Dowbiggin, *The Quest for Mental Health*, 12-14.
[29] François Furet, "Rousseau and the French Revolution," in *The Legacy of Rousseau*, eds., Clifford Orwin, Nathan Tarcov (Chicago: University of Chicago Press, 1997), 172.

the use of psychological therapy, Pinel argued that he could bring patients back to their naturally rational selves.[30] To accomplish this, and to have his methods become the model of care for mental illness, Pinel first had to invert the long-standing theory of mind-body dualism which had greatly influenced the treatment of the physically and mentally ill for over a century and half.

As Porter explains, in the seventeenth century, the mind became central to the philosophical understanding of human beings after René Descartes theorized that only reason could "rescue mankind from drowning in ignorance, confusion, and error."[31] In his famous aphorism, *Cogito, ergo sum* -- I am thinking, therefore I exist -- Descartes grounded philosophy in a reality which "equated the mind with the incorporeal soul."[32] Descartes posited that the mind was immaterial and without an identifiable space in the body, but that it connected to the individual through the pineal gland in the mid-brain. Far from joining mind and body together, Descartes ensured that the mind would be viewed as a "ghost in the machine," functioning separately from the body. This view of the relationship between the mind and body became known as Cartesian or mind-body dualism, and it proved to be a highly influential idea in philosophy and in medicine, especially as it changed perceptions of mental illness. Thanks to Descartes, consciousness was regarded as a rational element of the properly functioning human being. Conversely, insanity was thought to be caused by the interactions between the body and the brain, or like physical illnesses, madness was the result of an ailment in the body. Insanity was therefore no longer recognized as being demonic. This allowed for mental illness to be medicalized, and for mental patients to be

[30] Porter, *Madness*, 104-105.
[31] Porter, *Madness*, 56.
[32] Porter, *Madness*, 57.

treated in the same way as others.[33] For example, in Cullen's *First Lines on the Practice of Physic* from 1781, he wrote that mania required a depletive regimen of bleeding, purges, and emetics, while melancholia had to be treated through tonics and stimulants. Psychological factors were considered to be secondary to the somatic in causing insanity, though some physicians such as Robert Whyte, George Cheyne, and Cullen gradually acknowledged that they may play an important role.[34]

By 1800 however, Pinel was observing that the traditional forms of treatment were not effective in curing his patients and he wondered if mental illness was being viewed from the wrong perspective. In 1801 Pinel published his *Traité médico-philosophique sur l'aliénation mentale; ou la manie,* which described his new psychologically oriented method of treating madness. Tomes helps to illustrate that Pinel reconceptualized the mind-body relationship by reversing the "relative importance of psychological and somatic factors in mental diseases."[35] Pinel insisted that mental stress or trauma were the precipitating causes of insanity, while physical conditions were secondary. For Pinel, certain stimuli directly affected the mind and they caused madness. Having disordered the mind, these stimuli could then disrupt the health of the body. As Tomes succinctly puts it, "Pinel made the bodily ailments accompanying insanity its *effect* rather than its *cause* [her emphasis]."[36] Pinel felt that a tiny fraction of his patients became mentally ill as a result of organic brain or bodily disease, but the majority were caused by "traumatic events," which presented themselves in patients through "delusions, hallucinations, and loss of memory,"

[33] Porter, *Madness*, 55-58.
[34] Tomes, *The Art of Asylum-Keeping*, 77.
[35] Tomes, *The Art of Asylum-Keeping*, 78.
[36] Tomes, *The Art of Asylum-Keeping*, 78.

with physical symptoms often following closely behind. For example, someone suffering from mania might have an elevated pulse, while the melancholic could be constipated. More serious ailments may arise after prolonged periods of stress or sadness, and Pinel proposed that emotional or "moral" factors caused mental illness.[37] Through his novel interpretation of mind-body dualism, Pinel overturned earlier understandings of mental illness and this allowed him to restructure the ways in which these patients should be treated.

Crucially, Pinel insisted that the asylum was now the best place to conduct this form of psychological therapy. In these institutions, physicians would practice psychological medicine to treat mentally ill patients in entirely separate spaces of care from the physically ill. Through Pinel's version of psychological treatment or "*traitement morale,*" these "hopeless" cases could have their "faculties of reason" strengthened so that they may return to society. In this sense, some historians assert that the modern specialization of psychiatry began with Pinel.[38] Through his new psychological interpretation of mental illness, Pinel grounded moral therapy and the asylum in a persuasive theoretical framework which substantiated their use and ultimately led to their proliferation. Together these therapeutic ideas and institutional structures became the accepted norm in caring for the mentally ill.[39]

Soon asylums and moral therapy spread into North America. In the United States, the country's leading physician and Declaration of Independence signatory, Benjamin Rush, practiced a similar form of moral therapy to that of Pinel. Like his French

[37] Tomes, *The Art of Asylum-Keeping*, 78.
[38] Shorter*, A History of Psychiatry*, 11-12, 19; Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity* (New York: W. W. Norton, 1997), 495.
[39] Dowbiggin, *The Quest for Mental Health*, 20-22, 30-32.

counterpart, Rush was inspired by Rousseau's revolutionary ideas. Rush was particularly drawn to the notion that urbanization and commercialism were debasing humanity's "agrarian virtues," and that this was causing psychological alienation and mental illness. With this new understanding of the mind, Rush reasoned that it was imperative for moral therapy to be taught to new physicians and that specific hospitals should be built for the mentally ill. As an example of the circulation of these ideas, at the Pennsylvania Hospital in Philadelphia, Rush treated the mentally ill through moral therapy, gave lectures on the subject, and in 1812 published the text *Medical Inquiries and Observations upon the Diseases of the Mind*.[40]

As for the specific features of moral therapy and asylum care, psychiatrists sought to uncover the root causes of mental illness. The first step of moral treatment was to remove patients from their homes where stress and trauma were thought to originate. In asylums patients would not be physically restrained or bullied by staff, and physicians refrained from using heroic remedies. The tensions caused by urbanizing society would then be alleviated as patients calmed their minds within these therapeutic environments which were geographically distant from most city centres. In the institution, mental illness was to be cured through discipline, regular routine, proper diet, labour, and with asylum personnel using firm "guidance" to manage patient behaviour.[41] The structure and rules of the asylum granted patients the opportunity to reclaim their lost sense of self-control and their personal resolve. Asylum physicians meanwhile intended to treat patients with basic psychotherapy. Through discussion and observation, these physicians, or "alienists" (a

[40] Joseph Ellis, *After the Revolution: Profiles of Early American Culture* (New York: W. W. Norton, 2002), 61-62; Dowbiggin, *The Quest for Mental Health*, 23-24, 32.
[41] Reaume, *Remembrance of Patients Past*, 13-14.

name they adopted because of their work with people who suffered from "mental alienation") would find the cause of the patient's underlying disorder so as to restore them to their rational selves.[42] These early psychiatrists could also analyse the minds, conditions, and behaviours of each patient within this setting, thereby learning more about mental illness and the best ways to treat these afflictions.[43] Within each asylum, all manner of mental illness was treated. If patients were classified using modern definitions, asylums housed people suffering from schizophrenia, psychoses, and senility, as well as epilepsy, paralysis, tertiary neurological syphilis, other degenerative neurological disorders, and people living with various intellectual disabilities.[44] After the asylum and moral treatment had gained acceptance within the medical community, "progressives" wished to sweep away madhouses as relics of the "*ancien régime*." [45] Seen through the lens of intellectual history, these reformers steered medicine in a new direction as asylums with moral therapy allowed the young specialty of psychiatry to flourish as a separate branch of medicine in the first half of the nineteenth century.

Another aspect in medicine at this time which influenced the development of psychiatry was the formation of general hospitals. Though some European cities had been segregating their mentally ill into custodial institutions since the late-middle ages, there was also a long-standing tradition of housing the mentally ill in almshouses, poorhouses, jails, and hospices along with the physically ill, criminals, vagrants, and other "deviants."[46] Physicians meanwhile usually practiced medicine in the homes of patients who could

[42] Dowbiggin, *The Quest for Mental Health*, 27; Shorter, *A History of Psychiatry* 19-20.
[43] Porter, *Madness*, 105-107.
[44] Francis, "The Development of the Lunatic Asylum in the Maritime Provinces", 33; Porter, *Madness*, 118-119.
[45] Porter, *Madness*, 105-107.
[46] Shorter, *A History of Psychiatry*, 4; Moran, *Committed to the State Asylum*, 17.

afford house calls, or in almshouses, poorhouses, and hospices where the poor and working-class would go for medical care if they became ill or injured. At roughly the same time as Tuke developed the York Retreat and Pinel transformed the medical understanding of mental illness, physicians increasingly recognized that general hospitals, or centralized institutions for treatment, education, and research could help elevate their professional standing within the competitive medical marketplace.[47]

As historian Charles Rosenberg notes, physicians wanted to profit financially and professionally from the creation of a new kind of general hospital. To do this, physicians had to foster an environment in hospitals that allowed them to provide the best quality of care for wealthy and middle-class patients who could afford their services, or the "worthy poor" who physicians considered to be deserving of treatment. Physicians argued that to create this environment they had to remove the patients whom they could not help. Doctors reasoned that chronic and contagious cases should not be admitted into general hospitals. The two main reasons were that the presence of contagious people would be a danger to the staff and other patients, and because chronic cases would occupy valuable space in a facility where beds were meant for curable patients only. In both instances, these patients would undermine the curative objectives of the general hospital, and these institutions might quickly turn into almshouses. The mentally ill were also placed into this category as somatic physicians determined that their treatment methods could do nothing to cure these individuals, and that they were disruptive to the routines of the general hospital.[48] With asylums and moral therapy being born at roughly the same time as general hospitals, these

[47] Bynum, *Science and the Practice of Medicine in the Nineteenth Century*, 25.
[48] Rosenberg, *The Care of Strangers*, 19-24, 33-34.

developments ensured that psychiatric and somatic medicine would evolve on different paths throughout the nineteenth century. The mentally ill were now separated institutionally from the physically ill.

It is imperative for these factors to be taken into consideration when assessing the growth of the asylum and moral therapy in comparison to the general hospital and somatic medicine during this period, especially in North America. As Pinel launched his version of moral therapy in 1801, and with the York Retreat being called "the best-regulated establishment in Europe, either for the recovery of the insane, or for their comfort"[49] in 1812, North American psychiatry would follow the same blueprint, but it lagged behind the old world by a few years.[50] It must be noted that the Boston almshouse built a separate psychiatric ward for the mentally ill in 1729, while in 1752 the Pennsylvania Hospital was constructed and eventually they took in mentally ill patients. Additionally, in Williamsburg, Virginia, the first entirely separate psychiatric hospital was constructed in 1773, and another psychiatric ward was launched in the New York Hospital in 1791, with this same hospital raising its own distinct "Lunatic Asylum" in 1808. Yet these institutions largely practiced custodialism rather than curative moral treatment in an explicitly therapeutic asylum.[51]

Following in the reformative footsteps first set out by Rush, European style asylums began to emerge in North America after 1813 when Pennsylvania Quakers founded the Friends' Asylum in Frankford, Philadelphia. In Massachusetts, the McLean Hospital was

[49] William F. Bynum, "Rationales for Therapy in British Psychiatry, 1780-1835," in *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era London*, ed., Andrew Scull (London: London: Athlone Press, 1981), 43.
[50] Dowbiggin, *The Quest for Mental Health*, 21.
[51] Shorter, *A History of Psychiatry*, 7; Tomes, *The Art of Asylum Keeping*, 23-24.

established in 1818, the Bloomingdale Asylum in New York City was built in 1821, and the Hartford Retreat was raised in 1824.[52] Despite these supposed advances, Grob avows that this first generation of American asylums were still a lesser version of their European antecedents. Though Quakers such as Thomas Eddy wanted to recreate the York Retreat, the administrators of these asylums were still "uninformed of contemporary psychiatric theory" and the nuances of Pinel's psychological form of moral therapy. Consequently, the care offered in these institutions was only a slight improvement upon what was available in almshouses, and they left no lasting impact on American mental health care or public policy.[53]

By the 1830s however, American asylums were finally meeting the standards in moral therapy set by Pinel and the Tukes. One of the first asylums to achieve this distinction was the Worcester State Lunatic Asylum in Massachusetts. In 1833 Worcester opened its doors with Samuel Woodward as its superintendent. Though Shorter indicates Woodward practiced heroic treatments, Grob asserts that he adopted moral therapy and organized the facility so that patients could be treated quickly. This was another of the central tenets of moral therapy. These early psychiatrists argued that cases of mental illness had to be seen to swiftly. If treated shortly after symptoms emerged, insanity was supposed to be as curable as "any other acute disease of equal severity."[54] It is important to note that in contrast with the previous few asylums built in the United States, Worcester was a much larger institution, increasing from a patient population of 107 in 1833 to 359 by 1846. This

[52] Dowbiggin, *The Quest for Mental Health*, 21; Porter, *Madness*, 110.
[53] Gerald Grob, *Mental Institutions in America: Social Policy to 1875* (New York: London: Free Press; Collier Macmillan, 2009), 343.
[54] Grob, *Mental Institutions in America,* 98.

ability for greater expansion eventually led to Worcester becoming gravely overcrowded towards to the end of the century.[55]

Although Worcester acquired an exceptional reputation as an American moral asylum, similar reforms were slowly and unevenly distributed across the continent. If moral therapy was to become further engrained in the North American society, then additional activism was needed from outside of the medical community. In the 1840s, a former schoolteacher from Worcester named Dorothea Dix championed the cause of improving mental health care institutions. Her journey towards activism began in the 1830s when Dix fell ill. Her biographer, David Gollaher, writes that Dix was likely experiencing depression on top of her other infirmities. By 1836, her symptoms struck with such regularity and severity that she suffered a mental breakdown.[56] Due to her family's affluence, Dix was able to retire from teaching and upon the encouragement of her physician, she took an invigorating trip to England. Dix spent over a year in the country and on her journey, she found time to tour the York Retreat with Samuel Tuke.[57]

Dix returned to Boston in 1837 and quickly began an investigation into "the treatment of the mentally ill" in Massachusetts. As she inspected jails, almshouses and mental hospitals, Dix discovered many inmates and patients were living in squalor. Following her inspections, Dix submitted a "memorial" pamphlet to the state legislature which described the appalling conditions in these institutions.[58] To improve living conditions Dix promoted moral therapy all across the United States, Europe and Canada.

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[55] Grob, *Mental Institutions in America,* 98.
[56] David Gollaher, *Voice for the Mad: The Life of Dorothea Dix* (New York: The Free Press, 1995), 93.
[57] Manon S. Parry, "Dorothea Dix (1802-1887)," *American Journal of Public Health* 96:4 (April 2006): 624. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1470530/. (accessed 8 August 2020).
[58] Parry, "Dorothea Dix (1802-1887)," 624-625.

As Dowbiggin explains, Dix is widely regarded as having been responsible for "the founding or enlarging of more than thirty such institutions in the United States and abroad."[59] After a decade of reform work, Dix ventured to Nova Scotia and found that the mentally ill in the province were badly cared for. In a report she issued to the local legislature in 1850, Dix criticized the government for the poor standards of care that were on offer. She argued that Nova Scotia lagged behind the reforms that were already in progress elsewhere on the continent and that the province desperately needed a modern asylum grounded in moral therapy.[60] In a speech from 1963, Jones remarked that the government constructed the Mount Hope Asylum in 1858 because of the "pressure put on the legislature by the ubiquitous Dorthea *[sic]* Dix." Jones even gave her recognition for bestowing upon the Nova Scotia Hospital (NSH) its original name, the "Good Hope Asylum."[61]

As Dix set out on her mission of reform in the 1840s, a number of larger, more modern asylums modelled on the "principles of moral treatment expounded by Pinel and Tuke" were soon built in the United States.[62] A few prominent examples include the Maine Insane Asylum at Augusta which opened in 1840, the New York State Lunatic Asylum at Utica built in 1843, and the Butler Hospital for the Insane in Providence, Rhode Island in 1845.[63] Though it housed only fourteen patients, a small cholera hospital in Saint John,

[59] Dowbiggin, *The Quest for Mental Health,* 24.
[60] A. H. MacDonald, *Mount Hope Then and Now: A History of The Nova Scotia Hospital* (Dartmouth, N.S.]: Nova Scotia Hospital, 1996), 1-165; Murray*, Noble Goals, Dedicated Doctors*, 8; Francis, "The Development of the Lunatic Asylum in the Maritime Provinces", 25-26.
[61] DUA Jones, MS 13 14, Box 51, Folder 17, Trends in Psychiatric Care in Nova Scotia (1963), *Trends in Psychiatric Care In Nova Scotia* (20 September, 1963), 2.
[62] Tomes, *The Art of Asylum Keeping*, 74.
[63] Tomes, *The Art of Asylum Keeping*, 74.

New Brunswick was turned into the first official insane asylum in Canada in 1836.[64] Provisional asylums were then founded in Montreal in 1839, and Toronto in 1841. Dix also forwarded a "memorial" to the Legislature of Canada East and West in 1843, calling for humanitarian mental institutions to be built in these provinces. In 1845, the permanent Beauport Lunatic Asylum was established in Quebec City, while five years later the Toronto Provincial Asylum opened.[65]

In the vast majority of these institutions, especially those in the United States, the superintendents were all "Protestants reared in rural or small-town settings."[66] The most senior among this first generation of superintendents, Samuel Woodward — like many other physicians of this era — acquired his medical licenses only after apprenticing under older physicians and without gaining any formal medical education. However, as with orthodox physicians, some of the younger superintendents such as Pliny Early at Bloomingdale, or Isaac Ray in Maine, received medical school educations. By and large though, whether they apprenticed or went to medical school before passing a licensing exam, physicians learned little in the way of treating mental illness until they were employed in asylums. For example, Thomas Story Kirkbride, the superintendent of the Pennsylvania Hospital for the Insane from 1841 until 1883, studied in Paris, and eventually took the superintendent's position, but with much apprehension since he was not interested in caring for the insane. Only after accepting the job did Kirkbride read the relevant literature on moral therapy. Over time, these physicians gained first-hand experience which they believed was enough to adequately treat patients. By the 1840s, American

[64] Francis, "The Development of the Lunatic Asylum in the Maritime Provinces", 23.
[65] Moran, *Committed to the State Asylum*, 16, 62.
[66] Tomes, *The Art of Asylum Keeping*, 74

superintendents felt comfortable enough with the teachings of Pinel and Tuke to begin "formulating their own ideas about asylum treatment."[67]

Additionally, during the first two thirds of the nineteenth century, orthodox medicine had yet to gain the upper hand in the medical marketplace. As Bynum explains, "regular" medicine held no monopoly "as homeopathic, botanical, and eclectic doctors formed professional groups, opened their own schools, and vied for patients."[68] The "gentleness of the remedies" offered by alternative practitioners appealed to patients, especially considering that most orthodox physicians still used arduous heroic remedies without much success. Across much of the west, there was no guarantee of obtaining wealth or job security as a practicing physician.[69] The unstable nature of the industry meant that in the 1840s, any physician who obtained a superintendent's position at an asylum found not only a dependable source of employment, but also immense institutional authority which few other physicians anywhere in the medical community could attain. Using Kirkbride again, this "conservatively educated physician outside both the scientific and social elites of his profession" saw in asylum medicine an opportunity to "greatly enhance his power and reputation."[70]

Collectively, due to their similar medical educations, comparable professional experience, and religio-cultural backgrounds, this group of American asylum superintendents realized they were practicing a "unique, specialized form of medicine."[71] They soon developed close connections and in 1844, thirteen of these physicians founded

[67] Tomes, *The Art of Asylum-Keeping*, 44, 73-75.
[68] Bynum, *Science and the practice of medicine*, 182.
[69] Bynum, *Science and the practice of medicine*, 182; Shorter, *Doctors and Their Patients*, 51-52.
[70] Tomes, *The Art of Asylum Keeping*, 73.
[71] Tomes, *The Art of Asylum Keeping*, 75.

the Association of Medical Superintendents of American Institutions for the Insane (AMSAII), the first professional association for a medical specialty in North America.[72] As further indication of their stature in comparison to their somatic colleagues, in 1847 the newly established American Medical Association (AMA) approached AMSAII and asked if they would like to be incorporated into their new association. AMSAII declined the offer.[73]

Over the next two decades governments became more concerned with the mental health care of their citizenry. For many in government, the public, and medicine, the solution to mental woes brought on by the pressures of industrial society was to be found in the construction of more asylums. By 1880, there were 140 public and private asylums housing approximately 41,000 patients in the United States.[74] These numbers continued to soar well into the twentieth century. Following confederation, despite the Canadian population being much smaller and more dispersed than its southern neighbour, asylums were built from east to west between 1836 and 1891. With industrialization and urbanization being most prevalent in Ontario, seven mental hospitals were built in the province by the end of the nineteenth century. During this period, asylums became the most well-funded public institutions in North America and at the same time AMSAII and the power of the superintendents grew across the continent.[75]

This uneven balance between asylum superintendents and somatic physicians did not last long. By the 1880s science was beginning to revolutionize the therapeutic quality

[72] Tomes, *The Art of Asylum-Keeping*, 73-75; Dowbiggin, *The Quest for Mental Health*, 47; Dowbiggin, *Keeping America Sane*, 7-8.
[73] Shorter, *A History of Psychiatry*, 67.
[74] Dowbiggin, *The Quest for Mental Health*, 43.
[75] Dowbiggin, *The Quest for Mental Health*, 37-44.

and efficacy of orthodox medicine, lifting it past the alternative competition. Through Joseph Lister's antiseptic surgery, the rate of successful procedures rose dramatically because the threat of lethal infection in surgery greatly diminished. Paired with the use of anaesthesia, more complex and difficult operations could also be accomplished.[76] Furthermore, as Shorter explains, with the combination of new laboratory inventions such as the microscope, and the emphasis on bedside learning, the concept of the "modern" physician was born. Doctors would now be judged not by their capacity to "cure*"* diseases, but by their ability to correctly diagnose them. The two fundamental innovations which led to more accurate diagnoses came from pathology and microbiology. With the creation of the stethoscope by René Laennec in 1816, physicians started to listen into the body as a way to learn about the presenting symptoms within each patient. With the 1820s came greater advances in compound lenses and soon microscopes were more powerful and accessible. Together with the introduction of chemical stains for tissues, these tools allowed physicians over the next six decades to observe diseased organs at the microscopic level by looking closely at the cellular structures of the human body. Physicians now distinguished the physical changes in cells and tissues and compared them to the symptoms in patients. With peptic ulcers and stomach cancer as an example, physicians could study the cellular structure of each, and then discern the differences between the two as symptoms presented differently in patients suffering from these distinct afflictions. Then in microbiology physicians and scientists such as Rudolph Virchow, Louis Pasteur, and Robert Koch incrementally discovered that germs, bacteria, and microbes — formerly invisible enemies — were what caused diseases. Armed with this knowledge, physicians could discover

[76] Bynum, *Science and the Practice of Medicine in the Nineteenth Century*, 132-137.

where these creatures lived and how humans could avoid them. Together, these factors caused a revolution in somatic medicine. Physicians had finally acquired the tools, skills, and knowledge to accurately diagnose diseases, and patients were persuaded that doctors now had the power to heal. While these developments greatly improved the public image of all medical disciplines, effective therapeutics for psychiatry remained elusive.[77]

By the 1890s, psychiatry had fallen into a downward spiral, and its decline occurred as a result of many of the same societal forces which led to the rise of other medical specialties and the general hospital. With industrialization, urbanization, immigration, population growth, and new forms of transportation all intensifying in North America over the course of the nineteenth century, the public and governments felt the individual was facing a series of worries and stressors which were wearing people down. Psychiatrists argued the average person was increasingly under threat from the troubles caused by financial hardships, educational expectations, strenuous and alienating labour, societal politics, religious fervour, alcoholism, unhappy marriages, and ill health, and all of these factors were causing rates of mental illness to increase. At the same time, whether out of a need to control the unruly portions of society, or to try and legitimately help those less fortunate on the fringes of society, the notion of public welfare shifted from being a local and community problem, to a wider regional and national issue. As Dowbiggin explains, caring for the mentally ill had previously been carried out in the home or in the community, but it now became a "key component of public welfare policy made largely by elected officials and civil servants in state and provincial capitals."[78] By the middle third of the

[77] Bynum, *Science and the Practice of Medicine in the Nineteenth Century*, 37, 100-109; Shorter, *Doctors and Their Patients*, 75-78; Rosenberg, *The Care of Strangers*, 141-165.
[78] Dowbiggin, *The Quest for Mental Health*, 38.

century, since asylums were acknowledged as the "enlightened antidote" to mental illness, taxpayer dollars were used to build these institutions across the continent, typically "outside city limits and in bucolic settings."[79] Yet as the century drew to a close, the general hospital had overtaken the asylum as an object of government investment. This coincided with the public's growing fear of asylums as conditions in these institutions started to mirror the old madhouses which reformers such as Tuke, Pinel, and Dix had worked so diligently to improve.[80] What was once the remedy for mental illness was now a bitter pill. The prestige of asylums and the stature of asylum physicians plummeted in the medical community and in society.

The reasons behind the deterioration of asylums and psychiatry's poor reputation are numerous and multifaceted. However, historians today have shone a light upon the leading factors which triggered the decline of the specialty and its therapeutic facility. Since the time of Pinel and Tuke it was commonly understood by psychiatrists that it was best to have patients brought in for treatment as swiftly as possible. This would prevent the individual from becoming chronic and incurable. All members of the specialty concurred that once a patient's condition turned chronic, moral therapy could do little to cure them. As Shorter emphasizes, the asylum and moral therapy were meant to function "under the assumption that physicians and attendants would be able to spend time treating patients rather than simply warehousing them."[81] Yet paradoxically, asylum physicians by the latter years of the century dealt almost exclusively with incurable patients and "any hope of

[79] David J. Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston: Little Brown, 1971), xviii-xix; Dowbiggin, *The Quest for Mental Health*, 38-39.
[80] Dowbiggin, *The Quest for Mental Health*, 45, 37.
[81] Shorter, *A History of Psychiatry*, 46.

achieving the early reformers' ideals had been dashed by the flood of inmates hurled against the gates."[82] There were now too many patients being brought to asylums, and psychiatrists no longer had time to treat each person with the care and attention which moral therapy required.

Historians such as Moran and Reaume have rightly demonstrated that families regularly removed their loved ones from asylums, and that many patients were discharged "in an effort to present a more optimistic picture of the 'curative' nature of asylums."[83] However, when viewed in aggregate, asylum populations rose dramatically over the nineteenth century as a large percentage of patients "formed part of the critical mass of asylum inmates" who were never visited or removed from asylums.[84] The overcrowding which ensued is undoubtedly the primary factor which led to this decline in nineteenth century psychiatric medicine, but to understand why overcrowding happened, then some scrutiny of the mechanisms which caused it to occur must be assessed. One of the more convincing arguments which describes how overcrowding occurred has been articulated by Patricia Prestwich. She asserts that, despite the asylum becoming the norm in psychiatric care from a medical and governmental standpoint, families and older community-based approaches were still dominant. When a person developed mental illness, their families rarely opted to take them to the asylum right away. Instead, families "integrated the asylum into their own well-established systems of treatment for the mentally disturbed or

[82] Shorter, *A History of Psychiatry*, 46.
[83] Reaume, *Remembrance of Patients Past*, 209.
[84] Moran, *Committed to the State Asylum*, 3-6, 128-131; Reaume, *Remembrance of Patients Past*, 188-189, 209-223.

chronically ill."[85] Consequently, these families "made skillful use of various formal and informal resources available in the family, neighborhood, and the larger community."[86]

Families would do their best to care for a loved one at home, but they also sought help from neighbors, and often checked in with a local doctor to receive advice. As we know today, some cases of mental illness may improve on their own and a family would carry on with their lives if this occurred. Yet, other forms of mental illness may worsen over time.[87] In these instances, a patient could quickly drain a family's economic resources. They might also become a physical burden for the family to manage, and they could even turn into a violent threat within the home. Once the individual's condition had deteriorated to the point where they could no longer be cared for at home, the family was more likely to place the person in a nearby jail while they reassessed their finances and tried to figure out other ways of dealing with the individual. While in jail, the person was usually given medical treatment and on occasion a psychiatric evaluation. Families still regularly chose to take back their loved one, but from jails, the most serious cases were referred to asylums. By the time they arrived at an asylum, months or years may have gone by since the patient first developed their symptoms and psychiatrists had little hope of curing them through moral therapy.[88] Moran also emphasizes that, rather than reshaping the management of the mentally ill, the asylum became "integrated into a complex pre-existing network of medical and therapeutic responses to insanity."[89] Upon learning of the arrangements made by

[85] Patricia E. Prestwich, "Family strategies and medical power: 'voluntary' committal in a Parisian asylum, 1876-1914," in *The Confinement of the Insane: International Perspectives, 1800-1965*, eds., Roy Porter and David Wright (Cambridge, UK; New York: Cambridge University Press, 2003), 98.
[86] Prestwich, "Family strategies and medical power," 98.
[87] Shorter, *A History of Psychiatry*, 37.
[88] Moran, *Committed to the State Asylum*, 78-79.
[89] Moran, *Committed to the State Asylum*, 79.

families prior to committal, asylum physicians often blamed the lasting reliance on these networks for their inability to effectively treat patients because they were not sent to an asylum soon enough.[90]

Shorter adds that the apparent rise in mental illness during the nineteenth century was due to a "redistribution effect" and a legitimate increase in the rate of psychiatric illnesses. In earlier periods all members of a family lived in close proximity to one another. There was "little intimacy to disrupt" and few uniquely "private moments."[91] Towards the end of the eighteenth century, families urbanized and dispersed from their ancestral rural communities and a new intimacy of the home formed around the smaller family unit. If someone in this unit was to become mentally ill, they not only disrupted this blissful familial image, but families had neither the space, nor the support to care for this person. Through redistribution, cases of mental illness were "shifted from the family or the poorhouse to the asylum" because "patterns of sentiment in family life" had changed by the nineteenth century.[92] Statistically, Shorter shows that families by the 1880s were more willing to institutionalize their mentally ill relatives. At the same time, other forms of mental illness genuinely increased, especially neurosyphilis, alcoholic psychosis and, mysteriously, schizophrenia, which some argue was an entirely new condition which arose in the nineteenth century.[93] When observed collectively, each of these causal factors led to asylum overcrowding throughout the nineteenth century.

[90] Moran, *Committed to the State Asylum*, 79.
[91] Shorter, *A History of Psychiatry*, 50.
[92] Shorter, *A History of Psychiatry*, 50.
[93] Shorter, *A History of Psychiatry*, 48-64.

In the institutions themselves, as chronic and incurable cases poured in, most asylums ran out of beds for their patients and living conditions deteriorated rapidly. With so many incurable cases, patient populations aged and grew sicker each year.[94] As an example of asylum overcrowding, Reaume reveals that at Toronto's Queen Street Hospital after 1880, the institution's three-storey "cottages" housed some 50 male patients and 200 female patients. By 1917, the cottages were "condemned as unsanitary" and roughly 125 female patients were moved to a different reformatory to help ease the overcrowding at Queen's Street.[95] Also, in this institution, administrative offices were routinely converted into dormitories, and some patients slept on couches in hallways.[96] In Atlantic Canada, as Daniel Francis noted in 1977, the most critical issue was a lack of space.[97] For instance, an asylum meant for 200 people in New Brunswick contained 284 patients in 1877.[98] And at the NSH in 1882, superintendent A. P. Reid reported a "continually accumulating population" and that the wards were gradually filling with "the chronic and almost incurable insane."[99]

As patient populations rose annually, so did the cost of upkeep and care, with state and provincial coffers being consumed by these institutions. In the late 1880s, nearly 20 percent of the Ontario provincial budget was dedicated towards its six public asylums.[100] These facilities were now ostensibly warehouses for the mentally ill. Governments and politicians became more involved in the management and oversight of asylums, and tighter

[94] Dowbiggin, *The Quest for Mental Health*, 50.
[95] Reaume, *Remembrance of Patients Past*, 7.
[96] Reaume, *Remembrance of Patients Past*, 7-8.
[97] Francis, "The Development of the Lunatic Asylum in the Maritime Provinces", 36.
[98] Francis, "The Development of the Lunatic Asylum in the Maritime Provinces", 36.
[99] A. P. Reid, *Twenty-Fifth Annual Report of the Medical Superintendent*, Nova Scotia Hospital for the Insane, Appendix No. 3 (A), (1882), 10.
[100] Dowbiggin, *The Quest for Mental Health*, 50.

budgetary constraints were placed on superintendents in the United States and Canada. Many started to employ restraints again, use of sedatives increased, and psychiatrists were pressed into unwanted custodial and managerial roles. These psychiatrists "worried they were in danger of becoming virtual prison wardens"[101] as their jobs became more bureaucratic.[102] Rather than conducting patient therapy, superintendents spent most of their time ordering materials and food stuffs. One example of the duties and budgetary constrictions which came to dominate was the "Butterine" controversy involving Utica superintendent G. Alder Blumer. In February 1893, Blumer was attacked in the press by New York State governor Roswell P. Flower for ordering a cheap butter substitute from a meat-packing plant in Chicago. Clearly the therapeutic purpose of the asylum and moral therapy was disappearing. Blumer and New York State also serve as another example of what unfolded across much of the continent. In October of that year the state tightened asylum budgets and governments assumed more fiscal responsibility for the mentally ill.[103] As Reaume demonstrates these economic restrictions can be seen in the food served to patients and staff as the quality and variety declined over time. One patient at the Toronto Hospital wrote that "the food we get here is not fit for man at all" and blamed the food for causing sickness amongst patients.[104]

Furthermore, fiscal constraints meant that superintendents could not afford to hire extra physicians, nurses, or staff members. With fewer psychiatrists having to see more patients, the quality of treatment they were able to give was negligible. Not only did

[101] Dowbiggin, *Keeping America Sane*, 235.
[102] Reaume, *Remembrance of Patients Past*, 86; Cheryl Krasnick Warsh, *Moments of Unreason: The Practice of Canadian Psychiatry and the Homewood Retreat, 1883-1923* (Montreal and Kingston: McGill-Queen's University Press, 1989), 125-127; Grob, *From Asylum to Community*, 6.
[103] Dowbiggin, *Keeping America Sane*, 14, 43-45.
[104] Reaume, *Remembrance of Patients Past*, 54-61.

psychiatrists have little hope of delivering adequate therapy, but with so few physicians they were also unable to properly manage nurses and asylum staff which often led to the abuse and neglect of patients. As Ellen Dwyer has shown in late nineteenth-century American asylums, the presence of employees on asylum wards was far more important in the lives of inmates than the sporadic check-ins of physicians. Moran illustrates the same at the Toronto Provincial Asylum.[105] Reaume also highlights that staff and patients were not always in conflict, but with so many patients and few employees, there was more room for abuse and neglect to occur. For instance, with a nurse-to-patient ratio of one to 41 at the Toronto Hospital, there were simply not enough nurses to properly oversee patient care.[106] Between 1884 and 1890, there were three instances of a patient murdering another patient, while suicide was easier to accomplish since patients were regularly left without supervision.[107]

The situation was no better in Nova Scotia. Jones explained that in the 1890s, the province possessed the Mount Hope asylum, as well as a network of small regional county hospitals. According to Jones, these facilities were originally built on a sensible premise. In a region where travel was a challenge during inclement weather, families in rural areas did not want to run the risk of sending a mentally ill relative on the treacherous expedition to Mount Hope. Instead these county homes could house a loved one in a space close by. Although these homes seemed to fit within the standards of the new community mental health movement from Jones' era, he clarified that care within these small institutions was

[105] Ellen Dwyer, *Homes for the Mad: Life Inside Two Nineteenth-Century Asylums* (New Brunswick, NJ.: Rutgers University Press, 1987), 163-166, 177-183; James E. Moran, "Keepers of the Insane: The Role of Attendants at the Toronto Provincial Asylum, 1875-1905," *Histoire Sociale/Social History* 28:55 (May 1995): 56-58.
[106] Reaume, *Remembrance of Patients Past*, 235.
[107] Reaume, *Remembrance of Patients Past*, 54-61, 231-236.

miserable and they were "of a type that no enlightened community would tolerate for its animals."[108] Conditions at Mount Hope were also deplorable. In an 1877 investigation, one attendant reported that she found a female patient "stripped, bound and left unattended in a room with no bed and no heat, simply because she had torn her clothes." Since it was December, the patient froze to death, but the staff made no formal inquiry into the incident.[109] These issues were still apparent at the Halifax County Hospital when, in 1934, Alfred Millard, a patient with schizophrenia, beat another patient to death with an iron bar he ripped off of his cell door.[110] Whether additional staff members would have saved either patient is difficult to determine, but unquestionably if there had been more staff then the opportunities for neglect and abuse would have decreased.

The asylum superintendents and alienists, meanwhile, began to acknowledge that moral therapy and the asylum system were collapsing. One English physician admitted in 1870 that "Our whole scheme for the cure of lunatics has utterly broken down."[111] Due to their inability to cure the mentally ill, a deep sense of therapeutic pessimism swept through the profession and these specialists grasped at alternative explanations that would absolve them of responsibility. As Dowbiggin describes, between the 1880s and 1890s, many superintendents searched for answers or excuses which would explain why asylums had become so overwhelmed with patients, and why psychiatrists could do little to cure them. Prominent psychiatrists, such as Blumer, looked to heredity and degeneration (an idea

[108] DUA Jones, MS 13 14, Box 49, Folder 3, (n.d.) - R. O. Jones, Community Mental Health Medical Services Insurance in Nova Scotia, Robert O. Jones, *Community Mental Health Medical Services Insurance In Nova Scotia*, 2-4.
[109] Nova Scotia, *Supplementary Evidence as to the Management of the Hospital for the Insane,* Halifax, (1872); as cited in Francis, "The Development of the Lunatic Asylum", 36.
[110] "Investigation of Mental Institutions Urged: Province Behind Times in Treatment of Illness Society Told," *Halifax Chronicle*, (13 February 1934), 12b.; as cited in Fingard, Rutherford, *Protect, Befriend, Respect*, 33.
[111] Dowbiggin, *The Quest for Mental Health*, 50

promulgated by Francis Galton, who also coined the term eugenics in 1883). According to these theories, when two people with "undesirable traits" reproduce, they transmit mental illness or intellectual disabilities to their offspring. Over time, their descendants continue to pass these traits on, with mental illness becoming more dominant with each successive generation. This would allow for mental illness and disability to proliferate amongst society. At the core of hereditary taint and degeneration in North American were class and racial concerns. As eugenicists argued, the city dwelling European immigrants who flowed into American and Canadian cities were inferior to white Anglo-Saxon protest and were more prone to passing on these traits to their children.[112]

Canadian asylum physicians moved in-step with their southern counterparts and soon alleged that because of the "hereditary defectiveness" of immigrants, "foreign born patients were disproportionately represented in public asylums."[113] The leading Canadian advocate for these views was Charles Kirk Clarke, superintendent of the Toronto Hospital for the Insane. Like his provincial colleagues Richard M. Bucke, Daniel Clark, and James Russell, Clarke stressed the role which heredity played in "the incidence rates of insanity in the 1890s."[114] Today historians and scientists have resoundingly proven these ideas to be false. As Shortt poignantly adds, degeneration theory and heredity became crutches upon which psychiatrists braced themselves in order to protect their profession from blame. Degeneration theory "owed its appeal less to medical credibility than to its ability to explain and naturalize certain disconcerting realities of late nineteenth-century society."[115]

[112] Dowbiggin, *Keeping American Sane*, vii, 70-77, 144-146.
[113] Dowbiggin, *Keeping American Sane*, 138.
[114] Dowbiggin, *Keeping American Sane*, 18-19, 138.
[115] Shortt, *Victorian Lunacy*, 161.

Psychiatrists who subscribed to these views increasingly considered their patients to be hopeless cases and that moral therapy was useless as "an inherited neuro-psychiatric taint could not be expected to respond to even the most aggressive treatment."[116] With this negative attitude now permeating the specialty, attempts at curative therapy were largely abandoned.

By the 1890s, psychiatry was now more professionally isolated than ever from the rest of the medical profession. Some historians indicate that this isolation started first in medical school. Remember that physicians who entered into asylum work were rarely if ever educated on mental illnesses before they found work in these institutions.[117] In his assessment of Bucke, Shortt explains that when Bucke graduated from McGill medical school in 1862 he had learned virtually nothing about mental illness.[118] On this point, Murray offers additional insight into the lack of psychiatric teaching in medical schools during this period. In October 1890, Halifax physician George L. Sinclair wanted to retire from his position as the Chair of Medicine at Dalhousie after he was asked to instruct a course on neurological diseases. Sinclair argued that he was not fit for this task as he was not properly educated on such illnesses. Instead with his years of experience at Mount Hope, Sinclair proposed that he teach students about mental illness. Sinclair's colleagues scoffed at the idea and said that to offer a course on mental diseases would be to place too much importance on such an insignificant medical specialty.[119] It seems that the somatic physicians in charge of North American medical schools by the later years of the century

[116] Shortt, *Victorian Lunacy*, 161.
[117] Tomes, *The Art of Asylum Keeping*, 44, 73.
[118] Shortt, *Victorian Lunacy*, 4-10.
[119] Murray, *Noble Goals, Dedicated Doctors*, 124.

thought psychiatric medicine was so trivial that it did not need to be taught. Other historians and physicians have also noted that medical school students themselves were not interested in learning about mental illness, nor were they attracted to the specialty as a potential career due to the long hours, low wages, harsh working conditions, and what was widely perceived to be the ever present threat of violent patients.[120]

Within asylum practice, Shortt also provides evidence of the ways in which superintendents felt ostracized from the medical community. As superintendent of the Asylum for the Insane in London, Ontario, Bucke's administrative tasks accumulated to the point where he was "gradually stripped of all but the outward remnants of his medical identity."[121] Inside the asylum, Bucke found himself locked into the daily routines of his patients, while externally he was "governed by the will of the Inspectors and the regulations formulated by the provincial government."[122] As superintendents and psychiatrists adopted a custodial approach, rarely did they have the resources which allowed them to use the latest medical and scientific techniques in order to investigate the nature of mental illness as other specialties had done in the laboratory and the general hospital. The result was that other specialties, especially neurology, thought of psychiatry as a second-rate medical discipline "just a step, if that, above the spa-doctors and the homeopaths."[123] Many physicians thought that to practice psychiatry was to be banished to a geographically and professionally isolated realm of medicine.[124]

[120] Dowbiggin, *Keeping America Sane*, 115; Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 54-57.
[121] Shortt, *Victorian Lunacy*, 36.
[122] Shortt, *Victorian Lunacy*, 37.
[123] Shorter, *A History of Psychiatry*, 65.
[124] Shorter, *A History of Psychiatry*, 67.

In an effort to reorganize the professional interests of their specialty, in 1893 AMSAII decided to allow younger assistant asylum physicians and alienists into their association. Their new name became the American Medico-Psychological Association (AMPA).[125] For their fiftieth anniversary meeting in 1894, the association decided to invite American neurologist Silas Weir Mitchell to give the keynote address. When he began speaking, Mitchell wasted no time in setting an acerbic tone. "It is customary on birthdays to say only pleasant things," said Mitchell, "and this I knew I could not altogether do."[126] He went on to denounce asylum medicine and all those who considered themselves physicians in this specialty. Mitchell asserted that alienists sat and watched as advances came to other specialties while their profession "has won in proportion little."[127] He acknowledged this was partially due to the difficult nature of mental illness, but other factors had been more significant, particularly psychiatrists "tendency of isolation from the mass of the active profession."[128] Mitchell focused on the divisions which typically formed between specialties just after new fields began to differentiate themselves. Using ophthalmology, he explained how their methods, tools, and theories appeared to be quite different from the rest of medicine when the field was born. Over time however, general practitioners learned their terms and methods, and the two grew closer together.

With psychiatry though, "it has been different" said Mitchell.[129] They were the first of the specialists, but never fell back into line with the rest of medicine. Mitchell declared

[125] Shortt, *Victorian Lunacy*, 139.
[126] Silas Weir Mitchell, "Address before the Fiftieth Annual Meeting of the American Medico-Psychological Association," *American Journal of Psychiatry* 151:6 (July 1894): 29.
[127] Mitchell, "Address before the Fiftieth Annual Meeting," 29.
[128] Mitchell, "Address before the Fiftieth Annual Meeting," 29.
[129] Mitchell, "Address before the Fiftieth Annual Meeting," 29.

"Your hospitals are not our hospitals; your ways are not our ways."[130] He stressed that psychiatrists lived "cloistered lives" hidden away from the rest of medicine to the point where physicians from other disciplines were unable to examine their practices and theories.[131] This seclusion eliminated the opportunity for competition and critique which had become customary in somatic medicine. Mitchell admonished his audience for believing they were engaged in modern medical science and when in reality their annual reports were "odd little statements" on a few cases "sandwiched among incomprehensible statistics and farm balance sheets."[132] The title of "medical superintendent" was even an absurdity according to Mitchell as far too many of these men had acquired their postings through political patronage.[133] Mitchell then alleged that for too long superintendents had fooled the public into believing "that an asylum is in itself curative."[134] With his speech Mitchell had thoroughly articulated the major problems which had befallen psychiatry as the profession fell into turmoil by the last decades of the nineteenth century. Although Grob contends that Mitchell was not entirely opposed to the institutional care of the mentally ill, it is clear from his speech that psychiatric and somatic medicine now stood worlds apart.[135]

A hundred years earlier the asylum and moral therapy were heralded as the therapeutic solution to mental illness and the pressures of society. In the serene and relaxing spaces of the rural asylum, the patient's worries were to be soothed. By using a new interpretation of the relationship between mind and body, psychiatry was meant to

[130] Mitchell, "Address before the Fiftieth Annual Meeting," 29.
[131] Mitchell, "Address before the Fiftieth Annual Meeting," 33; Shortt, *Victorian Lunacy*, 140.
[132] Mitchell, "Address before the Fiftieth Annual Meeting," 32.
[133] Mitchell, "Address before the Fiftieth Annual Meeting," 29-30.
[134] Mitchell, "Address before the Fiftieth Annual Meeting," 33.
[135] Gerald Grob, "Abuse in American Mental Hospitals in Historical Perspective: Myth and Reality," *International Journal of Law and Psychiatry* 3:3 (1980): 302-303.

uncover the underlying emotional or moral problems within the mind, and personal therapy could cure mental illness. Despite a promising start, asylums grew crowded and any hopes of curative moral therapy were dashed. With the years dragging on, conditions within asylums worsened to the point where they started to resemble the madhouses of centuries past. With their ballooning patient populations, asylum physicians became bureaucrats who were far removed from the rest of medical science. As Mitchell pointed out, these physicians examined more balance sheets than patients, and they were more adept at filling out order forms than using the latest methods from scientific medicine to diagnose and cure their charges. Prominent psychiatrists such as Blumer and Clarke had previously acknowledged that their specialty was in grave danger of becoming irrelevant in the medical community. Both pursued reform, but by the 1890s with the state taking a greater role in asylum management it was impossible for them to make these institutions medically and scientifically modern.[136] In many ways Mitchell's speech proved to be a turning point for psychiatric medicine as it exposed the notion that the specialty was broken and in desperate need of mending. Into this North American context stepped Adolf Meyer, the young Swiss neuropathologist whose ideas sparked a new revolution in psychiatry. Meyer's ideas started to push the field closer to somatic medicine in the last years of the nineteenth century, and gradually the process of psychiatric normalization was initiated.

[136] Dowbiggin, *Keeping America Sane*, 23-28.

Chapter III

The Arrival of New Ideas and Adolf Meyer in North American Psychiatry

The process of psychiatric normalization can be better understood through an intellectual history approach, as well as through the reform ideas that shaped psychiatry since the end of the nineteenth century. As these ideas gained broad support amongst psychiatrists, they slowly helped to convince other practitioners to incorporate psychiatry into medical schools and general hospitals. Though dedicated mental hospitals would remain an important part of mental health care well into the twentieth century,[1] the ideas which were developed during this transformative era inspired a shift towards the use of providing psychiatric services in general hospital settings. Moreover, these reforms greatly affected the treatment which mentally and physically ill patients received, while they also altered the relationships that existed between both branches of medicine and led to psychiatry's acceptance by the medical mainstream. The present goal is to demonstrate that Adolf Meyer devised the theoretical, therapeutic, and infrastructural ideas which facilitated psychiatry's normalization. Over the course of Meyer's career from 1893 to 1941, the theories and reforms he developed fit into existing North American health care settings and allowed psychiatry to integrate within somatic medicine. More than anyone else in the field, Meyer helped to facilitate the normalization of psychiatry through his publications and students. As a result, psychiatry's standing was elevated as the specialty journeyed from isolated asylums to general hospitals and the medical mainstream.

[1] Grob, *From Asylum to Community*, 7-8.

Historiographically, Meyer's reputation as a positive force has long been in question, and even psychiatrists themselves noticed that Meyer was "forgotten by most in the field" after his death 1950.[2] As one example, Shorter suggests that Meyer may have been instrumental in medicalizing psychiatric treatment, but his impact on the field was "evanescent and parochial," and he was a "second-rate thinker" who embraced any new idea that cropped up whether it had therapeutic merit or not.[3] Other historians assess Meyer's legacy differently. Jack Pressman on two occasions wrote at length about Meyer and the ways in which he turned North American psychiatry into a "respectable medical specialty."[4] In recent years, Susan Lamb has taken up the challenge of decisively proving that Meyer left a permanent mark on psychiatry. As opposed to Shorter, Lamb affirms that Meyer's "wholesale and indelible influence on American psychiatry is the one thing about which historians agree."[5] On this point, sociologist Andrew Scull acquiesces, writing that Meyer was "the most prominent and influential American psychiatrist of the first half of the twentieth century" and that his influence was almost as strong in Britain.[6] Meyer was a single individual working within a vast intellectual network of other psychiatrists, physicians, and scientists. Many realized that change was needed in the field, but few conveyed a substantive plan to ameliorate psychiatry's tarnished reputation as a medical specialty. Certain psychiatrists tried to introduce reforms in the years before Meyer's career began, albeit with varying levels of success. All of these physicians were at the mercy of

[2] John R. Neill, "Adolf Meyer and American Psychiatry Today," *American Journal of Psychiatry* 137:4 (April 1980): 460; Oskar Diethelm, "In Memoriam Adolf Meyer, 1866-1950," *American Journal of Psychiatry* 107:101 (July 1950): 78-80.
[3] Shorter, *A History of Psychiatry*, 101-111.
[4] Pressman, *Last Resort*, 19; Pressman, "Essay Review: Psychiatry and Its Origins," 129-139.
[5] Lamb, *Pathologist of the Mind*, 1-3.
[6] Andrew Scull, *Psychiatry and its Discontents* (Oakland, California: University of California Press, 2019), 95.

external political, economic, social, and cultural forces which shaped the evolution of psychiatry towards the end of the nineteenth century. Unfortunately, many of these factors prevented the adoption of reforms which sought to amend psychiatry's status as a medical specialty. Primarily because of the institutional systems in which most psychiatrists worked, they were unable to bring about constructive change. However, by the time Meyer arrived in North America in 1893, asylum overcrowding and professional isolation had engulfed psychiatry. Long before Mitchell's speech, other reform-oriented physicians put forward proposals to help resolve these issues. Yet it was difficult for any meaningful changes to take hold because of the asylums' deeply embedded roots in North American society as well as the professional complacency and therapeutic pessimism which became pervasive amongst most asylum physicians.[7] Additionally, there was a lack of interest in psychiatry from other physicians and medical school students, and most psychiatrists lacked the necessary training to study mental illness scientifically.[8] When Meyer entered into the scene, he brought with him the scientific ideas and medical techniques which solved many of psychiatry's existential problems as he helped the specialty become more incorporated into orthodox medicine.

Furthermore, it must be conceded that Meyer did not produce these ideas in an intellectual vacuum. To understand his ideas and their impact, then, the professional, theoretical, medical, and clinical contexts in which he framed his ideas must also be considered. Given the environments in which Meyer was trained and the circumstances in the United States, he was able to imbue North American psychiatry with a new monistic

[7] Dowbiggin, *Keeping America Sane*, 27-49, 11, 59; Dowbiggin, *The Quest for Mental Health*, 70; Pressman, *Last Resort*, 21.
[8] Dowbiggin, *Keeping America Sane*, 48; Lamb, *Pathologist of the Mind*, 32.

understanding of the relationship between mind and body which was contained in his theory of psychobiology. Through this theory, Meyer was able to turn psychiatry into a more scientifically rigorous medical discipline, one that was open to cooperating with other specialties and professions, and this aided in psychiatry's assimilation into the broader medical profession. As Pressman argues, Meyer's ideas were supported by psychiatrists and philanthropic groups primarily because he "articulated a vision of a single profession united in theory, education, and practice."[9] Subsequently, the reforms he devised offered psychiatrists the opportunity to modernize as other medical specialties had done decades earlier. This reform process also medicalized and destigmatized mental illness. While most psychiatrists still worked in asylums, and others opted for private practice,[10] psychiatry was gradually included into more general hospitals, and medical schools greatly improved the quality of psychiatric teaching. These developments helped psychiatrists by bringing their discipline closer, both geographically and professionally, to other specialists in the medical mainstream. Furthermore, the mental hygiene movement broadened psychiatry's role in society as these physicians increasingly became responsible for managing the mental health of the public. This process took decades, and psychiatrists faced much resistance along the way, but major reforms came to the discipline and closer bonds formed between psychiatry and other disciplines over time. As a result, between roughly 1900 and 1970, psychiatrists were able to regain much of their lost credibility and broaden their social and medical purview. Nevertheless, despite the argument that Meyer enhanced the status of psychiatry, there is still much doubt as to whether these reforms ultimately improved the quality of

[9] Pressman, *Last Resort*, 19.
[10] Warsh, *Moments of Unreason*, 25-26.

mental health care, or if psychiatrists have ever attained professional equality with their medical colleagues.[11] The aim here however, is to explore how Meyer's ideas helped to normalize psychiatry across the United States, Canada and in Nova Scotia. By appraising Meyer's contributions, it can be demonstrated that the ideas he developed persuaded his contemporaries to adopt these approaches at a moment when reform in psychiatry was needed.

In observing the intellectual history of psychiatry, it is evident that after Silas Weir Mitchell's speech before the AMPA in 1894, the specialty could no longer ignore the reality that moral treatment and asylum medicine had failed. Psychiatry lost any claims it held on being a curative enterprise as superintendents became increasingly bureaucratic, and alienists acted as custodians of the chronically insane. Not only did they lack the time to carry out moral therapy, but they could barely supervise other staff members. Grob poignantly argues that asylums at this time were converted into "surrogate" homes for the "elderly and other kinds of chronic cases."[12] As populations increased and living conditions worsened, institutionalization often "provided the only means of survival" for "indigent aged persons."[13] Within these circumstances patient abuse occurred, but as Grob contends, abuse may have been exaggerated in the historical record. Reaume counters by insisting that the lack of physician oversight "cannot excuse or rationalize abuses that did happen in institutions that were, supposedly, places of refuge for troubled souls."[14] The fact remains

[11] Grob, *From Asylum to Community*, 303-304; Sam Sussman, "From Institutionalization to Community Care in Ontario," *Mentalities/Mentalies* 19:2 (2005): 28-33; Duncan Double, "The Limits of Psychiatry," *British Medical Journal* 324:7342 (April 13, 2002): 900-904; D. Bhugra et al., "EPA Guidance on How to Improve the Image of Psychiatry and of the Psychiatrist," *European Psychiatry* 30:3 (2015): 423-430.
[12] Gerald Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (New York: Free Press, 1994), 120.
[13] Grob, "Abuse in American Mental Hospitals in Historical Perspective", 306.
[14] Reaume, *Remembrance of Patients Past*, 73.

that all too often patients lived in foul conditions where they were abused and neglected, and with so many patients, staff could not provide proper care.[15]

As an example of the abysmal conditions in American asylums, Clifford Beers' 1908 book *A mind that found itself: An autobiography*, stands as a damning illustration of the abuse and neglect suffered by patients in mental institutions. The future leader of the mental hygiene movement wrote of his own experiences when he was institutionalized and revealed to the public what asylum medicine had become. In one disturbing scene, Beers recollected that days might pass without any incidents, but then "would come a veritable carnival of abuse—due almost invariably to the attendants' state of mind not to an unwonted aggressiveness on the part of the patients."[16] On another occasion, Beers wrote that a nearby patient was "so far out of his mind as to be absolutely irresponsible."[17] The staff beat the patient only because "he could not comprehend and obey."[18] This patient was persistently abused, with Beers reporting that he heard "the blows and kicks as they fell upon his body, and his incoherent cries for mercy were as painful to hear as they are impossible to forget."[19]

Physicians such as Bucke usually dealt with patients in a hurried and impersonal manner, and his dealings with attendants were "primarily in the guise of a disciplinarian."[20] There was little if any therapy conducted because physicians did not have time to treat patients. Beers likewise describes an abhorrent and all too common

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[15] Reaume, *Remembrance of Patients Past*, 73, 9, 38-44.
[16] Clifford W. Beers, *A mind that found itself: An autobiography* (Longmans, Green &, 1913), 169. https://babel.hathitrust.org/cgi/pt?id=chi.72645651&view=1up&seq=1&q1=treatment. (accessed 9 August 2020).
[17] Beers, *A mind that found itself*, 170.
[18] Beers, *A mind that found itself*, 170.
[19] Beers, *A mind that found itself*, 170.
[20] Shortt, *Victorian Lunacy*, 33.

aspect of asylum care: since budgets were constrained, superintendents had to make do with undesirable staff members, because they could not afford to hire anyone with superior training.[21] In one instance, Beers wrote that a homeless vagrant was hired right off the street and soon tended to an aged and indigent man. Though the attendant did not abuse or neglect this man, his lack of experience made him unable to interpret the patients' needs as he grew ill and unresponsive. Another attendant checked in only to find that the older man was near death. They both sent for a physician but were told by an administrator that the doctor was "too busy" at the moment. By the time the doctor arrived the man had passed away.[22]

Most medical professionals practicing in and outside of asylums acknowledged that overcrowding had ruined psychiatry. Yet despite persistent accusations of abuse and neglect, as well as the abandonment of treatment, asylums and moral therapy were nevertheless deeply imbedded in western society. Meaningful reform appeared to be unworkable. Dowbiggin posits that, even with this broken system, asylums remained the central method of mental health care for a variety of reasons. Foremost among them was that, aside from a few private asylums, the vast majority of mental institutions were taxpayer funded and state governments managed these institutions. Consequently, society as a whole was implicated in the continuation of this system. Many still felt strongly that asylums were necessary for the underprivileged, particularly when they needed to place a mentally ill family member into a shelter during times of financial hardship.[23]

[21] Reaume, *Remembrance of Patients Past*, 86-87.
[22] Beers, *A mind that found itself*, 312-313.
[23] Dowbiggin, *The Quest for Mental Health*, 69-70.

Regardless of abuse, or the public's aversion to confinement, most still held a positive opinion of asylums.[24] As social and economic historian Margaret Anne Crowther determined, from 1834 to 1929, the public by and large approved of institutionalization, and this included the poor and working class.[25] Despite the fact that these groups were "suspicious of institutions" and they were disproportionality committed to state asylums, they still supported mental institutions.[26] Even the charges of abuse and neglect did little to mitigate the asylums' popularity as there were no demands by the public or other reformers for alternative methods of care. They had also become too valuable in the health care and welfare apparatus of the state, and the public could not envision "a modern existence without it."[27] This meant that bringing innovations into such a vast and well-entrenched system was an enormous challenge for any reformers. Nevertheless, as Dowbiggin writes, "the struggle to improve mental health was well under way" by the end of the century and a cluster of German scientist-physicians were about to inject new ideas into psychiatry.[28]

For Meyer to develop his own ideas, they had to have been built upon those which came before him. Of considerable importance in the history of psychiatry is the work of Wilhelm Griesinger, "arguably the most influential mental scientist of the century."[29] During the latter half of the nineteenth century, the centre of scientific medicine shifted

[24] Shorter, *A History of Psychiatry*, 114; Dowbiggin, *The Quest for Mental Health*, 69-70.
[25] M. A. Crowther, *The Workhouse System, 1834-1929: The History of an English Social Institution* (Athens, Georgia: University of Georgia Press, 1982), 66.
[26] Michael Ignatieff, "Total Institutions and Working Classes: A Review Essay (Book Review)," *History Workshop* 15:1 (March 1983): 172.
[27] Dowbiggin, *The Quest for Mental Health*, 70.
[28] Dowbiggin, *The Quest for Mental Health*, 69-70; Shorter, *A History of Psychiatry*, 69.
[29] Mark S. Micale, "Henri F. Ellenberger: The History of Psychiatry as the History of the Unconscious," in *Discovering the History of Psychiatry*, eds., Mark S. Micale and Roy Porter (New York: Oxford University Press, 1994), 126.

from France to Germany, and the methods pioneered there influenced Meyer tremendously.[30] As physicians started to use scientific techniques to learn about somatic illnesses, some decided to focus their research on the brain. In Germany, Griesinger provided a new basis of scientific investigation which guided the specialty as he figured that the mysteries of mental illness must be contained within the brain's complex cellular structures. In the first issue of his *Archive for Psychiatry and Nervous Diseases* published in 1868, Griesinger hypothesized that patients with mental illnesses "are really individuals with illnesses of the nerves and brain."[31] Shorter labels this phase as the "First Biological Psychiatry" a period characterized by a loss in confidence in moral and psychologically based therapies.[32] Instead, psychiatrists were drawn towards neuroscience for more concrete evidence on the existence of insanity in the brain. Most notably, Griesinger infused psychiatry with elements from scientific medicine which were sorely needed in the specialty. He even recognized psychiatry's need to "emerge from its closed-off status as a guild and become an integral part of general medicine accessible to all medical circles."[33] Regrettably, many of the same techniques and philosophies which German physicians pioneered during this period were not be practiced on the other side of the Atlantic until the 1890s when Meyer imported them.[34]

By the 1880s, the use of the microscope in the study of brain tissues became popular in German, Austrian, and Swiss universities. Many of the scientists, physicians,

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[30] Bynum, *Science and the Practice of Medicine in the Nineteenth Century*, 95-103; Lamb, *Pathologist of the Mind*, 16-32.
[31] Shorter, *A History of Psychiatry*, 76
[32] Shorter, *A History of Psychiatry*, 69-112; Gerald Grob, "Adolf Meyer on American Psychiatry in 1895," *American Journal of Psychiatry* 119:12 (June 1963): 1136.
[33] Shorter, *A History of Psychiatry*, 69, 76.
[34] Lamb, *Pathologist of the Mind*, 18.

and psychiatrists in the region were confident they would discover specific lesions or disease entities for individual mental illnesses. At first there was some success as Ludwig Meyer found evidence of lesions in neurosyphilis patients. Yet other researchers began to realize through their own microscopic studies that not all psychiatric disorders "had to have a basis in the brain."[35] Though this was not conclusively proven until the 1920s by Franz Nissl, many physicians towards the end of the century were finding no correlation between a mentally ill person's symptoms and the condition of their brain post-mortem. There were no obvious lesions on the brain, nor were there any microscopic differences between the brain tissues of the sane and the insane specimen. Clearly there were puzzling elements at work within the minds of patients that were causing mental illness, and psychiatrists of the era were unsure of the way insanity developed. The unfortunate consequence of these discoveries was that psychiatrists thought degeneration and hereditary taint were the most convincing theories which explained the forms of mental illness which they could not observe under the microscope. Few in Germany at the time knew how to treat such conditions, and so they focused more on pathological research than clinical psychiatry or patient treatment. Worst of all this fed into the growing sense of therapeutic pessimism which was pervasive in psychiatry and led to wider support for eugenics.[36]

Even as new scientific investigations were happening in Germany, psychiatry in North America remained stagnant.[37] As an example, Blumer's predecessor at Utica, superintendent John Purdue Gray was influenced by Griesinger's *Archive*, and broke with the American field when he convinced trustees at Utica "to establish a pathology

[35] Shorter, *A History of Psychiatry*, 109.
[36] Shorter, *A History of Psychiatry*, 109, 76-80, 93-99.
[37] Shorter, *A History of Psychiatry*, 73-81, 99-109, 91.

laboratory" for the study of brain and spinal cord sections. Gray then became an opponent of Pinel's theories on the mental or moral causes of insanity and argued that the "mind cannot become diseased, but only the body."[38] Although Gray developed on these German ideas, he too was unable to improve the treatment of the mentally ill in asylums, nor did he elevate psychiatry's position in the medical community. As Tomes writes, the most prominent superintendents from the era, including Gray, still felt asylum architecture could cure patients, and that labour with nonrestraint "had much merit."[39] Gray however clearly believe that some restraints were necessary as he was brought before a state hearing in 1881 to discuss the conditions at Utica and the use of his notorious "Utica crib," a wooden bed used to confine disruptive patients.[40] In the ensuing decade Blumer tried to affirm the legacy of his predecessor by presenting Gray as a farsighted advocate for "scientific psychiatry."[41] But as Shorter explains, after Gray died in 1886, the histopathological laboratory was seen as "something of a joke among American psychiatrists."[42] Clearly North American psychiatrists had yet to acknowledge the value of scientific and pathological research.

In Germany, the neuroscientifically-oriented field was still at an impasse. Pessimism saturated the discipline as these scientist-physicians kept looking for answers through their microscopes. In this environment, psychiatrist Emil Kraepelin reshaped the profession's perception of mental illness as he convinced the medical community that these

[38] The words of John Purdue Gray cited by Meyer in; Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 5; Adolf Meyer, "The Rôle of the Mental Factors in Psychiatry," *American Journal of Psychiatry* 65:1 (July 1908): 39; Dowbiggin, *Keeping America Sane*, 14.
[39] Tomes, *The Art of Asylum Keeping*, 287.
[40] Dowbiggin, *Keeping America Sane*, 12.
[41] Tomes, *The Art of Asylum Keeping*, 318.
[42] Shorter, *A History of Psychiatry*, 91.

conditions were "as natural" as any somatic illness.[43] Within the history of psychiatry, Shorter asserts that Kraepelin is the specialty's central figure, not the more popular Sigmund Freud. From his clinic at Heidelberg in the 1890s, Kraepelin contended that to truly understand mental illness, psychiatrists had to study the development of symptoms in patients over time, that they evolved in the psyche and were exhibited through behaviour. In using case histories, Kraepelin gathered information on the patient's past and reconstructed the conditions in which they lived. In this way Kraepelin learned of the stresses and traumas of each patient, as well as their origins, and how their symptoms developed "across the years."[44] As Lamb writes, with case histories, Kraepelin began to compile patient data and perceived that many individual conditions fit into "distinct symptomatic patterns."[45] For Kraepelin, conditions such dysthymia, cyclothymia and depressive disorders, were grouped into a separate nosological category which he titled manic-depressive insanity. Kraepelin placed other conditions, namely catatonia, hebephrenia and certain forms of paranoid psychoses into the category of dementia praecox because these patients were thought to be incurable.[46] Ultimately, Kraepelin formulated three major diagnostic categories — dementia praecox, manic-depressive insanity, and paranoia — and argued that all mentally ill patients could be placed into either of these categories.[47] With patients being separated into distinct classifications, they could be

[43] Dowbiggin, *The Quest for Mental Health*, 48.
[44] Shorter, *A History of Psychiatry*, 99-100, 101-103.
[45] Lamb, *Pathologist of the Mind*, 48.
[46] Healy, *The Creation of Psychopharmacology*, 21-22.
[47] Hannah S. Decker, "How Kraepelinian was Kraepelin? How Kraepelinian are the neo-Kraepelinians? — from Emil Kraepelin to DSM-III," *History of Psychiatry* 18:3 (2007): 337. https://journals.sagepub.com/doi/pdf/10.1177/0957154X07078976. (accessed 11 August 2020); Assen Jablensky, "Living in a Kraepelinian world: Kraepelin's impact on modern psychiatry," *History of Psychiatry* 18:3 (1 September 2007): 383. https://journals.sagepub.com/doi/pdf/10.1177/0957154X07079 690. (accessed 11 August 2020).

grouped by like symptoms and given different clinical treatments based on symptom patterns.[48] This quantitative method which discerned "new forms of psychopathology" is regarded today as the first true "application of scientific principles" in the study of mental illness, and Kraepelin's ideas granted psychiatrists the ability to examine patients psychologically again.[49] These theories influenced the entire field and later inspired Meyer, but as psychiatrist Edward Cowles stated in 1896, Kraepelin was the "only German alienist who has attempted to study the particulars of psychological experiments." His approach was still an outlier in Europe and these ideas did not effect change in North America right away.[50]

Meanwhile in the United States and Canada, events in other specialties, particularly neurology, indirectly facilitated in the demarcation of clinical territory for psychiatry. Neurology emerged when European clinical research determined that some mental and nervous diseases were connected to the structures and functions of the nervous system. Following the American Civil War, the field grew in popularity after these physicians found that veterans had damaged their nervous tissues, and soon their treatment methods gained wider acceptance. By the late 1860s, neurology was cutting in on psychiatry's patient base. In the ensuing decades neurologists opened private clinics in urban centres, and many claimed an expertise not only over neurological conditions such as paralysis, chorea, and ataxia, but also illnesses which were formerly the exclusive domain of psychiatrists namely dyspepsia, anxiety, insomnia, depression, and general malaise.[51]

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[48] Healy, *The Creation of Psychopharmacology*, 292.
[49] Lamb, *Pathologist of the Mind*, 49.
[50] Edward Cowles, "The Advancement of Psychiatry in America," *American Journal of Psychiatry* 52:3 (January 1896): 381.
[51] Dowbiggin, *Keeping America Sane*, 10-11.

In the latter decades of the century, neurologist George Beard asserted that the pressures of modern civilization were causing peoples' nervous systems to break down, and negative long-term health outcomes would be the result if patients failed to seek treatment.[52] Beard and Silas Weir Mitchell both used the term "neurasthenia" to refer to these conditions and, in treating them, neurology ascended rapidly during the period of psychiatry's decline. Neurologists started to treat the wealthier middle-class in private clinics, while psychiatrists remained trapped in asylums.[53] However, as Pressman explains, neurologists "had unexpectedly stumbled upon a truth that undermined their own enterprise."[54] Traditionally they considered nervous disorders to be of somatic origin, but as they came to discover towards the turn of the twentieth century, some of the conditions they observed had no relation to the patient's nervous systems as they seemed to originate in the mind.[55] For example, with Mitchell's "rest cure," some patients with genuine neurological problems responded well to the diet and relaxation he prescribed. Yet for other patients, such as actress and novelist Elizabeth Robbins, neurasthenia improved through the discursive therapy received from the neurologist, and not from the massage or diet which she often rejected. This evidence made it clear that in certain patients, neurologists faced disorders which had a "major psychological component."[56]

At roughly the same time in internal medicine, some physicians noticed that patients with somatic illnesses "stubbornly resisted cure" even though they were examined and treated by dozens of expert specialists. Despite the rise of scientific medicine with all of its

[52] Anne Harrington, *The Cure Within: A History of Mind-Body Medicine* (New York: W. W. Norton & Company, 2008), 142.
[53] Shorter, *A History of Psychiatry*, 135-136.
[54] Pressman, *Last Resort*, 21.
[55] Pressman, *Last Resort*, 21-22.
[56] Shorter, *A History of Psychiatry*, 134-135.

new therapies and diagnostics, some diseases were seemingly not amenable to discovery or treatment. Meanwhile modern medicine had no explanation for the folk medicines and faith healers who were curing people with methods that medical science had deemed useless. Some somatic specialists now recognized that perhaps the mind played a greater role in the health of patients than they previously thought. This provided an opening for psychiatrists to investigate what appeared to be mental disorders. Together the three camps of alienists, neurologists, and internists "found common ground in the emerging psychopathology movement" which was fostered on Kraepelin's ideas. Suddenly, the range of conditions which psychiatrists claimed as being within their sphere of expertise greatly expanded as neurologists and internists surrendered wide swaths of patients to psychiatry. Not only were they in charge of severe and incurable cases of mental illness, but they could also treat patients for whom neurologists and internists had no cure. Young reformers in the field saw a new opportunity to develop "models of body and mind, of health and disease, and of treatment and healing" so as to reassert their authority within the medical community.[57]

In North America it was Meyer who most solidified psychiatry's new role in medicine, but to understand the ideas he introduced, it is crucial to first examine his own personal history, as well as the experiences and influences which shaped him. On September 13, 1866, Adolf Meyer was born in Niederweningen, a small Swiss parish roughly 25 kilometers north of Zürich, to parents Rudolph and Anna Meyer. A Zwingli Protestant minister, Rudolph was "well read and intellectually curious" while Anna was a "sensible and approachable" mother who "encouraged the interests of her children."[58]

[57] Pressman, *Last Resort*, 21-22.
[58] Lamb, *Pathologist of the Mind*, 32.

Meyer was also influenced by his mother's brother, a general practitioner. At 19, Meyer contemplated his future and was unsure if he should follow in his father's footsteps or pursue a career as a physician. If he became a pastor, Meyer felt that he would deal with "only a part of man."[59] In medicine, Meyer thought there were questions which modern science could not answer about the mind, body, consciousness, and philosophy, but he was curious to see what he might discover.[60] Unfortunately for future Zwingli parishioners in Switzerland, Meyer chose to study medicine.

With the support of his uncle, Meyer commenced his schooling at 19 with the renowned Professor August Forel. Shortly thereafter, Meyer wrote in his diary "I am glad that I have decided to study the whole of man."[61] When he began his training, Meyer wanted to emulate his uncle and thought of pursuing a career as a general practitioner. At University, though, Forel had an outstanding reputation as a brain anatomist and psychiatrist, and he was a pioneer in neuron theory who modelled his institution on Griesinger's and other German institutions.[62] Initially, Meyer was not gripped by psychiatry, but he found Forel's demonstrations captivating. Under Forel, Meyer developed a talent for histology and dissection. This approach was the hallmark of most German university clinics at the time and involved studying the body's cellular structures under a microscope.[63] At age 24, when Meyer was nearing graduation, he had become proficient at

[59] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 19.
[60] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 19. See Appendix, Image 1.
[61] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 19; Lamb, *Pathologist of the Mind*, 33.
[62] Lamb, *Pathologist of the Mind*, 31.
[63] Brian Bracegirdle, "The History of Histology: A Brief Survey of Sources," *History of Science* 15:2 (June 1, 1977): 77-101.

dissections, microscopy, and pathology.[64] Most importantly for his future, Forel and the German methods instilled in Meyer an appreciation for precise laboratory techniques and scientific practices. Yet Meyer grew tired of these exercises and the teachings of his professors especially as he wanted to learn more about the connections between mind and body. According to Lamb, after all of these hours spent examining specimens and learning from his teachers, Meyer believed he had yet to glean "any scientific insight into the role assigned to mental experience in the natural order."[65]

In 1890, Meyer obtained his medical degree, passed the state examinations and decided to continue his post-graduate education in France.[66] He still intended on becoming a general practitioner, but during his year abroad the ideas he encountered swayed Meyer to re-evaluate his ambitions. While in Paris, Meyer attended the lectures of Jean-Martin Charcot, the preeminent French neurologist of the era. Though he detested Charcot's "showmanship and dogmatism," Meyer was enthralled with the way in which Charcot demonstrated the correlation "between a patient's symptoms and life history."[67] When not attending lectures, Meyer was granted the opportunity to observe the laboratories of Joseph Jules Dejerine and Augusta Marie Klumpke. With Dejerine's permission, Meyer was allowed to walk the wards of the Bicêtre in order to examine patients and was asked to take note of the peculiar behaviours and thoughts of the patients he saw. As his Parisian sojourn came to an end Meyer wrote to his mother that he was pleased to have learned of the

[64] Richard N. Mitchell, "The Cell as a Unit of Health and Disease," in *Robbins & Cotran Pathologic Basis of Disease*, Vinay Kumar, et al., eds., (Philadelphia: Elsevier, 2014), 1. https://ebookcentral.proquest.com/lib/ottawa/detail.action?docID=1746677. (accessed 12 Augusts 2020).
[65] Lamb, *Pathologist of the Mind*, 33-34.
[66] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 20.
[67] Lamb, *Pathologist of the Mind*, 34.

"geniality and elegance" of the French neurologists and physiologists, and felt these aspects were missing from his German-Swiss education.[68]

The next stop on his post-graduate tour was Britain. As Meyer admitted years later, the most significant phase of his year abroad was his contact with "British soil and British thoughts."[69] Early on in London, Meyer realized that as the German schools valued laboratory and microscopic research, the British (with their attachment to Charles Darwin) concentrated on evolutionary biology and the physiological workings of the human nervous system. Additionally, where the Germans and Charcot relied on dogmatic theories, Meyer approved of the British reliance on empirical observation and thought it was worth emulating. More than any of the physicians he met in London, it was neurologist John Hughlings Jackson who most enthralled Meyer, especially his interpretation of the nervous system as being a product of human evolution. In studying Jackson's writings, Meyer was led to Herbert Spencer and Thomas Huxley who had been key influences on Jackson.[70] Years later, Meyer said in a speech to the Royal Medico-Psychological Association that he was struck by Huxley's "use of biological (life-dependent) rather than strictly physiological (organ- and structure-dependent) concepts" which characterized his training under Forel.[71]

Meyer stated in the same speech that he had high regard for Jackson's "capacity for observation" and his adherence to the principles of "evolution and dissolution rather than of a narrower concept of structure and function."[72] Meyer thought this was more useful clinically than the German approach as it supported the observation of patients under

[68] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 34.
[69] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 20.
[70] Lamb, *Pathologist of the Mind*, 67.
[71] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 27.
[72] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 34.

natural living conditions when "autopsy could not be obligatorily practiced."[73] Despite his enthusiasm for these ideas, Lamb clarifies that Meyer found aspects of Jackson's model "untenable."[74] Jackson believed the nervous system to be a "sensory-motor machine powered by reflex physiology."[75] In other words, the mind, brain, and nervous system react to stimuli which are encountered by the body both externally and internally. Through this view however, Jackson affirmed his support of mind-brain, or psycho-physical parallelism, another theory of the relationship between the mind and body. According to this theory, the physical and psychological events or stimuli experienced by the body and the brain, such as pain, happen in synchrony, causing a reaction in the nervous system. This information is communicated to the mind, but there is no causal interaction between them, and therefore mind and body are unrelated.[76] For Jackson, "mental states emerged during (but not because of) motor movements in the brain." But through his reading of the latest experimental research on the nervous system's cellular origins, Meyer thought Jackson's parallelistic notion that the mind, brain, and body had no causal interactions was deeply flawed. Not only did parallelism not fit within Jackson's own evolutionary view of the nervous system, but Meyer felt that Jackson was compelled to safeguard this view in order to prevent "metaphysics from distorting his scientific data."[77] In other words, to adopt a different view would have challenged Jackson's previous work. Regardless of the apparent problems in Jackson's theories, Meyer found that the overall British view of the human

[73] Lamb, *Pathologist of the Mind*, 34.
[74] Lamb, *Pathologist of the Mind*, 68.
[75] Lamb, *Pathologist of the Mind*, 68.
[76] Lamb, *Pathologist of the Mind*, 65; Elliott Sober, *Core Question in Philosophy: A Text with Readings*, 5th edn (Upper Saddle River, N.J.: Pearson Education, Inc., 2009), 256; Howard Robinson, "Dualism", *The Stanford Encyclopedia of Philosophy,* ed., Edward N. Zalta, Fall 2017 edn., https://plato.stanford.edu/archives/fall2017/entries/dualism/. (accessed 13 August 2020).
[77] Lamb, *Pathologist of the Mind*, 68.

being as a dynamic organism paired well with the French notions that the symptoms of mental and nervous disease could be observed in the life history patients. These ideas had a profound effect on Meyer and gave him an "invitation to explore" the relationships between mind and body which he so desperately wanted to understand.[78]

In 1892, Meyer pondered his future and considered general practice, but after his time away this vocation had lost its appeal. Having improved his English language skills, Meyer thought that working in the United States might be a possibility.[79] However, as Lamb explains, by this time Meyer's family life was in flux. His father had died not long ago, as did his sister Anna, and his brother Hermann left for business school in French Switzerland. Although his mother's life was now "utterly depopulated," Meyer made up his mind.[80] He was going to emigrate to America in order to pursue a career in neurological research. The only problem was that Meyer had no idea where he should go. Meyer acknowledged that if he were to focus on research, he may also have to establish a part-time practice to support himself. From the start he ruled out institutional work since he knew there was little independence or room for professional growth in American asylums. A position at an academic medical school was ideal, but these were few and far between with Johns Hopkins, Clark University, and Chicago being his preferred choices.[81]

As he prepared for his journey, Forel and Dejerine both suggested that Meyer should try his hand at psychiatry and clinical research with patients. In spite of their advice, Meyer was still wary about taking this route. He feared his English was not strong enough

[78] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 34, 20.
[79] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 23.
[80] Lamb, *Pathologist of the Mind*, 36.
[81] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 23.

to engage with patients, and he was convinced that if he were to excel it would be through "comparative neurology, not psychiatry."[82] While in Berlin, he met with Henry H. Donaldson, a neurobiologist who also studied at Zürich. Donaldson suggested that he should apply to Clark, but after a disappointing correspondence with Clark President Stanley Hall, Meyer opted to join Donaldson in Chicago.[83] Once he arrived in 1893 Meyer found the university's facilities and biology department were not nearly as well equipped as he was led to believe, and Chicago was essentially "a scientific desert."[84] Desperate to start research, he rented an apartment above a shoe store in the city and turned it into a small-scale neurological laboratory. Meyer also became affiliated with the local Pathological Society and took a part-time position at a hospital on the outskirts of Chicago managing its neurological dispensary. After Meyer gave a speech before the society on psychoneurotic patients, Dr. Ludvig Hektoen visited Meyer at his apartment. Hektoen explained he was a physician at the Kankakee mental hospital and told Meyer that the institution was in need of a pathologist. With few other options, and because the job provided "systematic access to brains," Meyer took the position in Kankakee, Illinois, a town roughly 100 kilometers south of Chicago.[85]

Meyer arrived at the institution in April, and much to his surprise, Kankakee was the first institution in America to implement a "noncongregate" system in which patients were housed in a network of small domiciles instead of one central building.[86] Although Meyer thought the asylum was an exceptional facility, far superior than any in Europe, he

[82] Lamb, *Pathologist of the Mind*, 39.
[83] Lamb, *Pathologist of the Mind*, 39; Shorter, *A History of Psychiatry*, 91.
[84] Shorter, *A History of Psychiatry,* 91; Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 43.
[85] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 44.
[86] Shorter, *A History of Psychiatry*, 91-92.

quickly noticed the systemic problems that were crippling asylums. For example, Meyer found himself working within a highly political and bureaucratic system where administrators knew virtually nothing about medicine. In the Illinois governor's election, Democrat John P. Altgeld defeated the Republican incumbent. Altgeld then set about clearing out the managerial staff of most asylums due to corruption charges. This meant that superintendent Richard Dewey, the man who hired Meyer, was already replaced with Dr. Shobal V. Clevenger by the time Meyer arrived at the institution. Four months later Clevenger resigned, and he was replaced by Dr. Clarke Gapen. In amongst this managerial disorder, Meyer's paycheques were misplaced. When he went to the board of trustees to rectify the problem, one of the board members asked Meyer "What's a pathologist?"[87] This entire incident can be seen as an indictment of the state asylum system: those making the managerial decisions were more interested in politics and budgets than patient care or scientific medicine.

The problems at Kankakee also went far beyond the front office. Meyer found that the medical staff lacked ambition and were "hopelessly sunk into routine and perfectly satisfied with it."[88] He urged his colleagues to be more scientific and to keep accurate and complete clinical records, but most were content with the status quo. In one instance which shows the level of psychiatric and neurological education present in the staff, Meyer performed an autopsy for the asylum foreman. The foreman, who was a physician, watched as Meyer examined the specimen, determined the cause of death, and then began to assess the brain. At this point the foreman spoke up and said "Now, doctor, show us what you find

[87] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 46-47.
[88] Shorter, *A History of Psychiatry*, 91-92.

in the mind." Meyer replied that if the case records and patient history of this specimen were more detailed and comprehensive, he could glean insight into the patient's mental illness. As for the brain, Meyer had to explain that it told him little about mental illness.[89]

With the institution's routines firmly set, Meyer struggled to get his fellow physicians more interested in modern medical science. This proved to be a chore as many were entirely apathetic to his ideas. Having come to this realization, Meyer decided to organize informal examinations where he encouraged staff members to assess new patients during recreation periods. In conducting these unofficial training sessions, Meyer tried to impress upon his colleagues the importance of "extensive history-taking, extensive investigation, and extensive notetaking," all of which became trademarks of the Meyerian approach.[90] Shorter also writes that while the Germans were fanatical with the microscope, and the British were dedicated to nonrestraint, Meyer became obsessed with "the facts." Meyer gather virtually every detail about a patient.[91] Thanks to his diligence, the ambitious Gapen and the trustees who were "sensitive to political criticism," granted Meyer the opportunity to teach a summer course in neurology and psychiatry to physicians and medical school students.[92] The benefit of the course was that Meyer trained physicians to be proficient hospital assistants, and the medical services provided by state asylums were much improved. Soon his influence was spreading throughout the mid-west as physicians such as Albert Moore Barrett came from Iowa to attend his classes.[93]

[89] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 47-48.
[90] Shorter, *A History of Psychiatry*, 92.
[91] Shorter, *A History of Psychiatry*, 92; Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 47.
[92] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 49.
[93] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 49-50.

Meyer had worked at Kankakee for just over a year when Mitchell gave his speech to the AMPA at Philadelphia. Gapen attended the meeting and returned to Illinois outraged. Evidently the famed neurologist was ignorant to "some of us lesser known and less favored beginners" as he failed to mention any of the new innovations at Kankakee.[94] Meyer himself stated before the AMPA in 1928 that Mitchell's charges were "not primarily based on a study of the facts," and that they were "expressive of a lofty (although not any too understanding) criticism."[95] In response to the attack, Meyer "accepted Mitchell's strictures as a personal challenge."[96] The first step of his counter-offensive was to send a copy of Mitchell's speech to Altgeld as well as a circular letter which included the views of other asylum physicians. The following year Meyer then sent a report to the Governor which outlined the major problems facing psychiatry, while he also put forward some of the reform ideas which later reshaped psychiatry. From the beginning Meyer pointed out that the mentally ill had long been the victims of prejudice, and even the cured were stigmatized by society years later as were their relatives. Meyer argued that in Europe, mental diseases were not an "intrinsic part" of university medical school curriculums, but each physician had to study the topic to pass their licensing exam. In the United States, Meyer wrote "most students leave college without having any idea about mental diseases."[97] If the subject was taught, neurologist were usually the instructors, and they only interned at asylums. Since this system did not produce a high standard of education on mental illnesses, what American students received was "utterly deficient." The end result according to Meyer was

[94] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 50.
[95] Adolf Meyer, "Presidential Address: Thirty-Five Years of Psychiatry in the United States and Our Present Outlook," *American Journal of Psychiatry* 85:1 (July 1928): 6.
[96] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 50.
[97] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 54.

that "few physicians can be considered qualified to act in the most difficult of all kinds of diseases."[98]

To correct these problems, Meyer proposed that the state should erect clinics for the mentally ill in "medical centers," that they should establish "facilities for clinical study" in asylums, and that to obtain a license, students must complete courses in the study of mental illness at either a college or an asylum. The report also addressed treating patients more rapidly, possibly even in their own homes with a nurse. Furthermore, Meyer affirmed that asylum conditions across the state needed to improve, that the institutions themselves had to have "all the facilities of an ordinary hospital," and that asylum physicians could no longer remain isolated from the rest of the somatic specialties.[99] With this report Meyer addressed many of Mitchell's criticisms and he outlined how psychiatrists could improve their standing in the medical community. Meyer later claimed that this persuaded Altgeld to institute competitive examinations for internships at all Illinois state asylums. This at least ensured that a higher standard of intern was accepted into each institution.[100]

Meyer remained at Kankakee in 1895 but the position was wearing on him. As he wrote years later, the structure at the institution guaranteed that the daily tasks of the physicians remained custodial and separate from scientific research. This created "corners that are never swept."[101] Though Gapen supported some of these ideas, he was hesitant to adopt Meyer's approach which placed the living patient at the centre of clinical pathological research and treatment.[102] At the annual AMPA meeting held in Denver that

[98] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 50-55.
[99] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 58.
[100] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 50, 54-58; Lamb, *Pathologist of the Mind*, 46.
[101] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 77.
[102] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 77.

year, Meyer learned first-hand that some of the leading figures in the field were more open than Gapen to his ideas. Following his presidential address, Edward Cowles from Boston's McLean Asylum met with Meyer and discussed the possibility of him developing a scientific research program at the Worcester asylum. Knowing that improvements at Kankakee were unlikely, Meyer jumped at the opportunity. As Lamb explains Meyer now had the chance to prove that if mental illness were to be treated scientifically "the work of the pathologist must begin long before the autopsy."[103]

After his departure from Illinois, Shorter describes Meyer as "a kind of Johnny Appleseed" who planted the ideas of scientific general "medicine" or "psychiatry" into every institution he worked in.[104] Shorter also notes that Meyer had a habit of using the words medicine and psychiatry synonymously. This was purposeful and the language Meyer used helped in normalizing psychiatry within somatic medicine. As Pressman explains, in Europe, physicians who treated mental diseases were called psychiatrists. When Meyer came to America, he brought the term with him and used it to refer to all physicians who dealt with mental illness. Since Meyer worked in asylums where alienist had been the preferred term, his use of psychiatry slowly led to the displacement of "alienist."[105] By using "psychiatry" and "medicine" interchangeably, Meyer signalled that the treatment of mental illness should be considered as a part of general medical practice.

In the fall of 1895, Meyer arrived at the Worcester. His role was to act as a research scientist and clinical supervisor, and he was to apply the "organized clinical system" he

[103] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 77; Lamb, *Pathologist of the Mind*, 47.
[104] Shorter, *A History of Psychiatry*, 92.
[105] Pressman, *Last Resort*, 19-20.

developed at Kankakee in this institution.[106] Meyer entered Worcester with much enthusiasm as he believed that superintendent Hosea M. Quinby was going to support his reform ideas. In a letter Meyer received from Quinby following his meeting with Cowles, the superintendent wrote that Worcester was in need of a physician who could combine pathology, neurology, and psychology. Quinby also wanted Meyer to create a training school for nervous diseases in connection with Clark University. Through the training school, Meyer taught the hospital's assistant physicians the latest in scientific medicine in hopes this would attract young physicians to asylum practice.[107] Yet within a few months, Meyer was bothered again by many of the same issues he found at Kankakee. The physicians working in Worcester practiced custodial care and few had any desire to provide treatment. Through his own observations Meyer reasoned that physicians at Worcester were overwhelmed by the number of patients. As Meyer assessed the figures, the asylum had a population of 1200, and 600 new cases were admitted each year, while only four physicians worked in the facility. With so few doctors, Meyer found himself getting involved in more patient treatment than he anticipated. He demanded that the psychiatric staff be doubled in an effort to ameliorate patient care. His demands were met, but the four extra physicians did little to release the immense pressure on the asylum staff.[108]

Since the training school was connected to Clark University and Meyer was a member of the faculty, he felt the need to discuss his situation with Stanley Hall.[109] On December 7th, 1895, Meyer a wrote a letter to Hall which is known today as *The Worcester*

[106] Lamb, *Pathologist of the Mind*, 47.
[107] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 78.
[108] Meyer, "Presidential Address", 9, 16.
[109] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 78.

Plan. In the letter Meyer explained that he left Kankakee because he found it impossible to supervise 2100 patients. Despite its lower population, Meyer found patient care at Worcester was poor and the medical staff were indolent.[110] Meyer then wrote that the asylum's administrator believed he was being frugal by not hiring more physicians. Meyer thought this was counterproductive and reasoned that with more staff, better laboratory facilities, and a library, the staff could actually treat patients. This would lead to a decline in the population, and the state would save money.[111] Meyer also stressed that Quinby misunderstood the objectives of psychiatric medicine since he wanted Meyer to focus on "interesting and acute cases."[112] For Meyer this was "a great fallacy" as the medical staff should look "at all cases equally well," and that their approach had to be standardized so as to give every patient the same examination. Meyer proposed that psychiatrists take meticulous notes because they "*must* exclude the fallacies of memory."[113] This allowed them to build a base of clinical material and patient data upon which to assess symptom patterns and to provide a more appropriate treatment approach for each patient.[114] Though this appears to be a common sense approach, only Kraepelin was using a similar methodology at the time, and when Meyer brought this to Hall's attention he emphasized that Kraepelin only ever had 150 patients on hand, not 1200.[115] Meyer then noted that work in asylums was clerical, and as a result young physicians saw psychiatry as a professional and scientific dead end.[116] Hall was receptive to Meyer's concerns and eventually gave him

[110] DUA Jones, MS 13 14, Box 51, Folder 25, (1939-41), Robert O. Jones Papers Supplement 1, Personal Papers, Adolf Meyer at Johns Hopkins Meyer, Adolf Meyer, *The Worcester Plan* (7 December 1895): 5, 6, 7.
[111] DUA Jones, Meyer, *The Worcester Plan*, 9-10.
[112] DUA Jones, Meyer, *The Worcester Plan*, 14; Grob, "Adolf Meyer on American Psychiatry in 1895", 1141.
[113] DUA Jones, Meyer, *The Worcester Plan*, 14; Grob, "Adolf Meyer on American Psychiatry in 1895", 1141.
[114] DUA Jones, Meyer, *The Worcester Plan*, 15; Grob, "Adolf Meyer on American Psychiatry in 1895", 1141.
[115] DUA Jones, Meyer, *The Worcester Plan*, 16; Lamb, *Pathologist of the Mind*, 48.
[116] DUA Jones, Meyer, *The Worcester Plan*, 12.

title of "clinical director." Meyer made regular rounds of the asylum, conducted daily staff meetings, and slowly changed the culture at Worcester whereby the medical staff became interested "in the wide range of real cases."[117] As successful as Meyer had been, Lamb writes that his tenure at Worcester was often frustrating, "miserable, and lonely."[118] It vexed him that Quinby preferred to keep "administrative order" above all. For instance, Meyer wanted to hire a pharmacist, but Quinby rejected the request because there "was no available place at the dining table assigned to staff members of a druggist's social rank."[119]

In need of a reprieve Meyer travelled to Europe in the summer of 1896 and made his way to Kraepelin's Heidelberg clinic where he learned directly from Kraepelin for six weeks.[120] At the clinic, Meyer found that the professor thoroughly examined each patient while the facility acted as a "transit station through which the greatest number of patients were admitted, observed, and diagnosed."[121] Meyer paid careful attention to Kraepelin's methodology which collected and compared "observations of all cases to reveal otherwise indiscernible pathological patterns."[122] This proved to Meyer that his intuitions had been correct. In emulating Kraepelin's broader approach by making detailed patient histories and scrupulously documenting every aspect of examinations, he aimed to improve upon the clinical model he had established at Worcester.[123] While Meyer approved of the clinic overall, he had some misgivings about Kraepelin. As Lief wrote, Meyer thought psychology should have played a larger role in patient treatment at Heidelberg. Instead

[117] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 81.
[118] Lamb*, Pathologist of the Mind*, 52.
[119] Lamb*, Pathologist of the Mind*, 52.
[120] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 83.
[121] Lamb, *Pathologist of the Mind*, 48.
[122] Lamb, *Pathologist of the Mind*, 49.
[123] Lamb, *Pathologist of the Mind*, 48-49.

Meyer saw "psychology snowed under nosology, or groupings," and that Kraepelin's focus on classifications depersonalized patients.[124] Meyer could not deny however that Kraepelin made an extraordinary triumph which surpassed all previous psychopathological discoveries. After he left Heidelberg, Meyer "took from Kraepelin's principles only what was acceptable" and then applied them at Worcester "in a mitigated form."[125] Meyer then toured some of the other top institutions on the continent, but concluded in 1898 that after seeing such a diverse set of perspectives, he became convinced in the "correctness of my principle."[126] For Meyer, psychiatrists had to combine clinical, laboratory, and autopsy findings into a general pathological approach, and they had to be open to collaboration with other specialties and professions such as sociology, psychology, and social work. Together these elements were sure to improve North American psychiatry.[127]

Although Meyer's time with Kraepelin shaped his approach to the study of mental illness, it was the experience he had with his mother which most propelled him towards becoming a psychiatrist. Shortly after taking his position at Kankakee, Meyer received word that Anna had been hospitalized for delusional depression. She was put under the personal care of Forel, but he feared that Anna's condition was incurable. Over time, Meyer saw that numerous patients who suffered nervous breakdowns due to familial trauma and financial stress were able to recoup their mental faculties. As Meyer was formulating his own theories on the environmental causes of mental illness, he realized that the death of his father and sister, as well as the financial debt which Anna incurred to fund her son's voyage

[124] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 83.
[125] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 83.
[126] Lamb, *Pathologist of the Mind*, 49.
[127] Adolf Meyer, "A Few Trends in Modern Psychiatry," *Psychological Bulletin* 1:7-8 (15 June 1904): 222; Lamb, *Pathologist of the Mind*, 49, 254.

to the U.S., likely caused her condition to develop. Though Forel thought it unlikely, Anna eventually made a full recovery, and Meyer was able to visit with her during his trip. Meyer stated years later that her affliction made psychiatry "real" to him, while it served as an example which proved therapeutic pessimism was incorrect. Clearly some disorders could improve.[128] Meyer now aimed to investigate the evolution of mental disorders by studying the personal histories of patients as well as their behaviours so as to find out how stress and trauma influence the mind over time. According to Jones, this episode in Meyer's life "illustrated perhaps the importance of his mother's depressive illness in giving Adolf a lifelong urge for improving the treatment of psychiatric patients."[129] With his journey through Europe at an end, Meyer returned to Worcester with a new outlook. He no longer identified as a neuropathologist. Meyer was now a clinical psychiatrist.[130]

Meyer returned to America with a greater sense of direction, but the asylum system was still inert. Psychiatry had yet to gain further professional respect, and many somatic physicians held the view that mental illness must be observable under the microscope. For instance, in 1897, physician Henry W. Coe gave an address to the Portland Medical Society in Oregon and quoted a "Dr. Williams" who said doctors with little experience in treating the mentally ill "seek to ignore its presence unless it is accompanied by positive evidence of material derangement," and that they demand further proof of its existence beyond observable behaviour.[131] To change the situation at Worcester, Meyer intended to remodel the institution using the insights he gained from Heidelberg with his own adjustments to the

[128] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 83; Lamb, *Pathologist of the Mind*, 46.
[129] DUA Jones, MS 13 14, Box 51, Folder 25, (1939-41), Robert O. Jones Papers Supplement 1, Personal Papers, Adolf Meyer at Johns Hopkins, Robert O. Jones, *The Meaning of Adolf Meyer*, (1973): 6.
[130] Lamb, *Pathologist of the Mind*, 50.
[131] Henry W. Coe, "The Care of the Insane in Private Practice," *Journal of the American Medical Association* 28:10 (6 March 1897): 435.

Kraepelinian system. Rather than a concentration on epidemiology and patient diagnostics, Meyer wanted to figure out what caused mental disorders and how he might cure patients. The first step was to amass case histories on the asylum's patient population so that "causal patterns" could be found. With these histories, Meyer sought to analyse the data in an effort to understand how mental disorders developed in each patient. As Lamb explains, this approach mirrored those found in other medical specialties with "comparative analyses" informing "diagnostic reasoning," as well as future research directions and "possible medical interventions."[132] Though Meyer was beginning to see mental illness as derived from the reactions of human beings to their environment and that they were capable of developing psychologically, his views remained on the fringes of medical consensus as the Coe article illustrates. Additionally, as Lief wrote, the scientific world at this time "still acted on the assumption that reality was divisible into physical and mental spheres which must stay separate."[133] Yet Meyer believed that by using a scientifically rigorous methodology, psychology would be accepted by somatic physicians and integrated with biology.[134]

Meanwhile, in the psychiatric and neurological community, Meyer gained praise. At the annual AMPA meeting in 1897 neurologist Bernard Sachs gave a speech in which he commended Meyer and suggested that his work should be emulated as "asylum reports were fast becoming storehouses of useful investigations."[135] At Worcester however, Meyer recognized that Quinby was a stifling influence as he wanted Meyer to study the most

[132] Lamb, *Pathologist of the Mind*, 50.
[133] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 84.
[134] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 84.
[135] Bernard Sachs, "Advances in Neurology and Their Relation to Psychiatry," *American Journal of Psychiatry* 54:1 (1897): 1-19; Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 81;

bizarre and unique patients. Meyer argued to Quinby that the path towards a scientific understanding of mental disorders was through a systematized approach where all cases were examined in the same way. Dishearteningly, Meyer was opposed on this point by some of the medical staff who were satisfied in thinking that laboratory work was in itself scientific as though autopsies and microscopy were enough. As had happened at Kankakee, Meyer grew tired of Worcester because reforms advanced too slowly.[136]

With professional disagreements at Worcester, Meyer was grateful when the New York State Commission in Lunacy sought his advice on their Pathological Institute. After his presentation before the Commission, Blumer — himself a committee member — vowed to Meyer that they would follow his recommendations by turning the institute into a teaching facility, and that their new director would be a clinical psychiatrist. In writing his brother the following week, Meyer stated that after putting forward his proposal to some of the most powerful physicians in his field, he believed that he had "done more for the reform of psychiatric enterprises in America than ever before."[137] The commission were so impressed by Meyer that in 1901 they asked if he would be their new director. He accepted their offer and quickly left Worcester behind.[138]

From this position Meyer reshaped the thirteen state mental hospitals according to his vision of a systematized and scientific form of psychiatry. Physicians in each institution were educated in the latest techniques, and as many began to thoroughly examine their patients, they gained a greater interest in their jobs as well as "their patients' problems."[139]

[136] Lamb, *Pathologist of the Mind*, 51.
[137] Lamb, *Pathologist of the Mind*, 54.
[138] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 95.
[139] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 101.

Though the road to improving psychiatry's position in the medical community was fraught with challenges, especially as some psychiatrists and physicians were resistant to his ideas, there are a number of examples where others began adopting Meyer's methods.[140] For instance, in 1903, a New York asylum physician thanked Meyer for instructing him on the best means of finding out "all there was to know about a patient."[141] By implementing a Meyerian approach, this physician described how he was able to curb the use of restraints and prescribed fewer sedatives. As Grob affirms, Meyer's practices "may have had indirect benefits" for patients. Just by taking the time to gather a life history, psychiatrists "conveyed a message that staff was concerned with patient problems and needs."[142] Grob and other historians also insist that despite Meyer's dissatisfaction with the perceived lack of progress at Kankakee and Worcester, the reforms which he instituted at both facilities, as well as in New York, caused a paradigmatic shift. In all of these institutions there could be no relapse to the earlier custodial system.[143] Before 1908, the reforms which Meyer introduced helped to ameliorate patient care, while his ideas initiated the merger between psychiatry and the medical mainstream as psychiatrists started to see their specialty as part of general medicine. For example, in a 1907 Isham G. Harris, a psychiatrist at Hudson River State Hospital, wrote that "Psychiatry is an important branch of general medicine," and that because of Meyer's direct management, the New York system "stands foremost in the line of advancement."[144]

[140] Lamb, *Pathologist of the Mind*, 57.
[141] Grob, *The Mad among Us*, 146.
[142] Grob, *The Mad among Us*, 146.
[143] Lamb*, Pathologist of the Mind*, 54.
[144] Isham G. Harris, "Psychiatry and It's Importance," *Medical Record* 72 (26 October 1907): 687.

At this moment Meyer's influence was permeating into Canada through C. K. Clarke. After years spent working in asylums such as the Hospital for the Insane in Toronto, and the Rockwood Hospital for the Insane in Kingston, Clarke was hired as superintendent of the Toronto General Hospital in 1905.[145] Though Clarke later became a therapeutic nihilist, and a supporter of eugenics, for the first few years of the century he and Meyer held analogous views on treating the mentally ill. Like Meyer, Clarke thought these afflictions should be dealt with medically in the same way as physical illnesses, and that the best setting for therapy was in general hospitals, not asylums. Clarke also believed that the public should be educated on these illnesses so symptoms could be identified in their initial stages. Though Clarke still felt asylums served a useful purpose by sheltering the severely ill, he argued that curative therapy was an impossibility in these facilities because of overcrowding.[146] Faced with the problems of asylum care, Clarke began to look abroad for solutions.

Beginning in 1907 Clarke was part of a commission which surveyed European psychiatric institutions, especially one of Kraepelin's clinics in Munich.[147] Once Clark returned, he then sought inspiration south of the border. In a 1912 issue of the *Bulletin of the Ontario Hospitals for the Insane*, Edward Ryan, another member of the commission, wrote that they toured "the most advanced State Hospitals in the neighboring republic."[148] In his brief retrospective on psychiatric research in Canada, R. A. Cleghorn writes that new

[145] C. M. Hincks, "Charles Kirk Clarke, M. D., LL. D," *American Journal of Psychiatry*, 80:4, (April 1924), 838; Edward Shorter, *Partnership for Excellence: Medicine at the University of Toronto and Academic Hospitals* (Toronto: University of Toronto Press, 2013), 354-356.
[146] Dowbiggin, *Keeping America Sane*, 26-32.
[147] Cyril Greenland, "C. K. Clarke: A Founder of Canadian Psychiatry," *Canadian Medical Association Journal* 95:4 (23 July 1966)" 158.
[148] Edward Ryan, "Seven Years' Advance In The Ontario Hospitals For Mental Disease," *The Bulletin of the Ontario Hospitals for the Insane* 6:1 (October 1912): 4.

institutions were developed in New York, Boston, Michigan, and within a few short years at Johns Hopkins. As they were built, Clarke and others in the Canadian field were drawn to the approaches being employed in the U.S. With Meyer having influenced the New York and Massachusetts systems, Cleghorn explains that he helped to establish "the intellectual foundation" of the field in North American, as well as the "opportunities for evolving approaches."[149]

With success having followed Meyer from Illinois to New York, it was clear that he had established a reputation as the leading reformer of psychiatry in North America. Over the sixteen years spent working in asylums, Meyer proved he was a talented neuropathologist and an industrious researcher, as well as a capable teacher and a proficient clinician. Subsequently, when Johns Hopkins decided to open a psychiatry department in 1908, these strengths made Meyer the logical choice to be the chief of psychiatry at the celebrated university medical school.[150] In May 1908, the trustees of the university sent a letter to Meyer informing him that the medical board and the board of advisers at Johns Hopkins Hospital "had unanimously recommended him as director" of the new Henry Phipps Clinic and as head of their psychiatry department.[151] Meyer swiftly accepted the position and soon met with Henry Phipps himself, the Pennsylvania Steele magnate. Together with Phipps's architects, Meyer had the building designed precisely to his specifications as it was to be a living laboratory to study patients, to teach students, and to test his theories.[152] From October 1909 onward, Meyer took an active role at the university,

[149] R.A. Cleghorn, "The Development of Psychiatric Research in Canada up to 1964," *Canadian Journal of Psychiatry* 29:3 (1984): 189.
[150] Lamb, *Pathologists of the Mind*, 24.
[151] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 336.
[152] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 335-337; Lamb, *Pathologist of the Mind*, 110. See Appendix Images 2 and 3.

but when the Phipps Clinic opened on April 16, 1913, Meyer became America's "preeminent psychiatrist." He maintained this status for much of the first half of the century.[153]

With Meyer having taken his seat at the head of North American psychiatry, the reform ideas he formulated flowed throughout the psychiatric community and were gradually accepted by his peers. Moreover, through his students' successive generations of new psychiatrists were trained in Meyer's specific approach. Yet in reviewing Meyer's formative years as a neuropathologist turned psychiatrist it was crucial for his influence to be recognized. As has been made clear, late nineteenth-century psychiatry was not void of new ideas. Due to the political, economic, social, and cultural circumstances in North America at the time however, the asylum had become a well-entrenched fixture. It became difficult for new ideas to penetrate the dominant system and psychiatry was particularly resistant to change. Coming from Europe, Meyer was a conglomerate of the ideas and influences he was exposed to, and though he was hesitant to work within asylums, once he found employment at Kankakee, he saw that the specialty was in need of reform. Now, from Johns Hopkins, his theories and practices circulated across the continent. With the spread of Meyer's ideas and eventually the migration of his students, the necessary intellectual setting was being fostered in which psychiatry's normalization into mainstream medicine could commence.

[153] "Specialism in the General Hospital," *British Medical Journal* 1:2733 (17 May 1913): 1066; Lamb, *Pathologist of the Mind*, 99, 2; Theodore Lidz, "Special Section, Adolf Meyer, 1866-1950, Adolf Meyer and the Development of American Psychiatry," *American Journal of Psychiatry* 123:3 (1966): 321; Pressman, *Last Resort*, 19-20.

Chapter IV

Meyerian Reform Ideas and the Normalization of Psychiatry

As chief of psychiatry at Johns Hopkins, Meyer gained a level of authority in his field which equalled that of other famed Johns Hopkins physicians such as William Osler and William Welch. From this position Meyer was able to bring greater attention to his scientific and experimental approach which he labelled the "new psychiatry" in 1901.[1] Meyer was joined by August Hoch, Smith Ely Jeliffe, Morton Prince, and William Alanson White, as well as other young American psychiatrists and neurologists who all thought similarly about the nature of mental illness. By the century's first decade many in the group determined that a firm distinction between sanity and insanity should be abandoned. They reasoned that a more accurate view was one in which abnormal and normal behaviour developed along a "common spectrum."[2] Furthermore, Meyer endeavored to abolish what he saw as "an artificial picture of psychiatry," one that was based on data collected in the unnatural environment of "large, isolated asylums."[3] Now as head of psychiatry at the nation's leading academic medical school, Meyer was free to implement all of his theoretical ideas in this new clinical and research setting.[4]

From Johns Hopkins, Meyer was able to spread his theoretical, treatment, and reform ideas across the continent like never before. The initial means Meyer used to

[1] Lamb, *Pathologist of the Mind*, 101.
[2] Lamb, *Pathologist of the Mind*, 101.
[3] Meyer, *The Commonsense Psychiatry of Adolf Meyer*, 149.
[4] Lamb, *Pathologist of the Mind*, 24.

circulate his ideas was through knowledge transfer venues such as the *American Journal of Psychiatry.* Most importantly, as a professor, Meyer could pass on his ideas and methods to new academic psychiatrists as well as the medical school's other general practitioners and specialists. Once these psychiatry students graduated, they then migrated across the continent where they advanced Meyer's reform strategies in the varied locales in which they came to practice and teach.[5] Unlike his previous appointments, Johns Hopkins gave Meyer the opportunity to remake North American psychiatry on a much broader scale.[6] As a result of the circulation of Meyer's ideas and the diaspora of his students, the process of psychiatric normalization unfolded between roughly 1900 and 1970 across the United States, as well as in United Kingdom, and in local settings such as Nova Scotia.

Crucially, after analysing Meyer's articles, as well as those of his colleagues and the archival materials of Nova Scotian psychiatrist Robert O. Jones, it is possible to determine that Meyer's reform strategy consisted of six main ideas. For Meyer, psychiatry had to become a medical science, mental illness needed to be medicalized, and the locus of psychiatric care needed to shift from asylums to general hospital inpatient units, outpatient clinics, and community care clinics. Meyer also aimed to improve psychiatric education in university medical schools, and he helped found and direct the mental hygiene movement. These ideas subsequently allowed psychiatry to undergo a transformation during the twentieth century. After studying Meyer's writings, it becomes clear that these reform ideas were centred around psychobiology, a theory he formulated between 1893 and 1908.[7] Psychobiology is the most significant of his ideas, and it was the lynchpin of Meyer's entire

[5] Lamb, *Pathologist of the Mind*, 54.
[6] Lamb, *Pathologist of the Mind*, 2, 254.
[7] Lamb, *Pathologist of the Mind*, 60.

approach to psychiatry which he used to understand the nature of mental disorders. It also shaped the way he treated patients, and all of his students were taught the theory, as well as the psychobiological approach to psychiatry. Meyer also used psychobiology to solve "what he considered obstacles preventing psychiatry from operating as a clinical science and medical practice." Without it, the bulk of his reforms might have been rudderless and ineffective if such a theoretical foundation had not been conceived.[8]

The theory itself is still known for its complexity, but Lamb offers the most thorough description. Meyer's understanding of evolutionary biology from the British meant that he viewed theories which divided mind from body as flawed. As he came to understand, both mind and body had to have developed within the human organism over the course of its evolution. With this view Meyer also rejected other materialistic or mechanistic interpretations of mind and body as he saw that the two were indivisible aspects of the whole human organism. Additionally, through the influence of American pragmatists such as psychologists William James and John Dewey, Meyer was convinced that "mental activity was a causal force" in human beings, and it shaped the way each individual interacted within their environment. This affirmed the notion for Meyer that mental illness could develop in the psyche itself, and that materialistic or dualistic explanations missed this integral aspect.[9] In 1897, Meyer first presented this view and described how the anatomy, physiology, and psychology of the human being grew directly out of the "fertilized ovum of a mother."[10] From these microscopic beginnings he

[8] Lamb, *Pathologist of the Mind*, 60.
[9] Lamb, *Pathologist of the Mind*, 4-5, 215.
[10] Adolf Meyer, "A Short Sketch of the Problems of Psychiatry," *American Journal of Insanity* 53 (1897): 538-539.

hypothesized "The body and its mechanical and chemical functions, and the mental life associated with it, make out the biological unit, the person."[11] Within each person the development of the mind occurred in unison with the anatomical and physiological aspects, but not "merely in a parallelism, but as a oneness with several aspects."[12] Upon these suppositions, Meyer understood that mind and body were inseparable, and that the body's anatomical and physiological nervous apparatus, as well as its mental activities and behaviours were all were part of a "single adaptive response of the human organism" to the stimuli in their environment.[13]

Actions undertaken by the human being mentally and physically, as well as the reactions a person experienced due to external and internal stimulation constituted, for Meyer, a psychobiological reaction. Through psychobiology, mental, neural, behavioural, and anatomical components of the individual person were all incorporated together in the human organism, so no part of the human being was divisible from any other. Consequently, if this theory was to function within psychiatry and medicine, then Meyer specified that mind-body dualism and other flawed theories had to be discarded. The reason being that the mental and the somatic were inseparable aspects of the whole organism and all facets of the human being were vital to the way each person adapted to the challenges in their environment. Consequently, according to psychobiology, mental illnesses were not well-defined ontological diseases. Rather they were mental disorders that matured in each organism over time as a result of the way in which they adapted to those anatomical,

[11] Meyer, "A Short Sketch of the Problems of Psychiatry," 539.
[12] Adolf Meyer, "A Short Sketch of the Problems of Psychiatry," *American Journal of Insanity* 53 (1897): 539.
[13] Lamb, *Pathologist of the Mind*, 21.

physiological, or mental stimuli found in their environments. If an individual reacted or adapted poorly to those stimuli, then gradually their behaviours changed to the point where a disorder developed within their psyche.[14]

For Meyer it was conceivable that each person could succumb to the emotional, mental, and physiological stresses that might confront them when changes took place in their environment. In such instances, Meyer argued that a mental disorder could arise in a person psychopathologically as the challenges they faced may cause "disharmony of those regulations" which balanced their personality.[15] To restore order, Meyer tried to learn of the environment and history of the patient. Through psychobiology, the patient could be taught to remove the stresses from their home environment and how to respond to their negative adaptations or maladjustments more positively. Unlike some of his contemporaries who grew pessimistic towards treatment, Meyer's theory allowed for the mentally disordered to regain stability after curative or adaptive treatment was applied. For instance, as William C. Garvin, a New York psychiatrist and pupil of Meyer wrote in 1929, the psychobiological approach helped to "prevent subsequent breakdowns" as patients learned how to deal with their disorders.[16] This made psychiatry like other medical specialties who had specific pathological methods and therapeutic techniques.[17] Meyer also thought that when a person experienced a seemingly somatic illness with no apparent organic cause, the symptoms of the patient's condition might actually be rooted in the psychological adaptations which occurred when the person was faced with new or long-term challenges in their

[14] Lamb, *Pathologist of the Mind*, 21, 60-61; Pressman, *Last Resort*, 20.
[15] Meyer, "The Rôle of the Mental Factors in Psychiatry", 39-43; Pressman, *Last Resort*, 23-24; Lamb, *Pathologist of the Mind*, 89-90.
[16] William C. Garvin, "The Influence of Modern Psychopathology in State Hospital Practice," *American Journal of Psychiatry* 85:4 (January 1929): 662.
[17] Lamb, *Pathologist of the Mind*, 58-61.

environment. These health problems would eventually become known as psychosomatic conditions.[18] Consequently, Meyerian psychobiology bridged the divide between the psychiatric and somatic branches of medicine as his approach combined scientific investigations with medical therapy as none of the older moral therapists or pessimists had done previously.[19]

Yet despite the prestige of Johns Hopkins, Lamb writes that it was difficult for Meyer to convince his colleagues of the benefits of psychobiology. For example, in 1914, psychiatrist G. V. Hamilton, in Montecito, California, gave his own assessment of "Adolf Meyer's psychology."[20] At first Hamilton applauded Meyer noting that "psychiatry owes much to Meyer's efforts to develop a 'psycho-biology' or 'dynamic psychology,' which shall be more directly and more generally applicable to therapeutic problems than is the psychology of the text-books."[21] Hamilton then passed judgement on psychobiology as he felt Meyer's attitude toward the mind-body dualism unnecessarily complicates "a situation into which the psychiatrist cannot afford to drag philosophical issues."[22] This indicates that Meyer did have trouble in getting psychobiology adopted by the rest of the field at first. But as Detroit physician Groves B. Smith suggested in 1927, "The psychobiologic point of view of Meyer has steadily gained ground."[23] Furthermore, as Meyer's student Theodore Lidz argued decades later, after Meyer put forward his theory, it helped to overturn "the

[18] Diethelm, "In Memoriam Adolf Meyer, 1866-1950", 80; Suzanne R. Karl and Jimmie C. Holland, "Looking at the Roots of Psychosomatic Medicine: Adolf Meyer," *Psychosomatics* 54:2 (March-April 2013): 111-114; Lamb, *Pathologist of the Mind*, 206-208; Pressman, *Last Resort*, 32.
[19] Lamb, *Pathologist of the Mind*, 203-204.
[20] G. V. Hamilton, "An Estimate of Adolf Meyer's Psychology," *American Journal of Psychiatry* 71:2 (October 1914): 339.
[21] Hamilton, "An Estimate of Adolf Meyer's Psychology," 341.
[22] Hamilton, "An Estimate of Adolf Meyer's Psychology," 341.
[23] Groves B. Smith, "The Psychoneuroses: Their Problems in the General Hospital," *Journal of the American Medical Association* 89:23 (3 December 1927): 1949.

mind-brain parallelism that had stifled thought and thwarted research concerning mental problems."[24] Although Meyer found it difficult to win his contemporaries over to psychobiology, it is clear that it left an impression on North American psychiatry. As Meyer rejected older mind-body hypotheses, he replaced them with a new theory that tied psychiatric medicine to the somatic specialties, while it also stimulated others in psychiatry to view the specialty as a true medical science.

One example of Meyer's scientific ideas being communicated in the medical literature can be found in an article written in 1915 by one of his assistant resident physicians, Edward J. Kempf. In "The Behaviour Chart In Mental Diseases," Kempf educated readers on some of the latest scientific techniques practiced at Johns Hopkins such as patient examination records, life charts, and data collection. As Lamb explains, this standardization of record keeping enabled Meyer to "execute the collaborative practices of scientific medicine and clinical teaching" which were crucial for psychiatry's integration with other specialties.[25] Kempf asserted that in the majority of asylums, psychiatrists in these settings were often inundated with patients and this made the collection of accurate patient data difficult. Yet, this meant it was even more important for psychiatrists to keep meticulous notes and to ensure that patient examination information and case histories were properly organized. This would assist them in systematically studying patient files more easily. To gain more insight into their patients, Kempf recommended they adopt the use of Meyerian behaviour charts so they may "extend research into the more fundamental,

[24] Lidz, "Special Section, Adolf Meyer, 1866-1950", 322, 326.
[25] Lamb, *Pathologist of the Mind*, 151-159.

obscure and involved factors of behaviour."[26] Through the chart, they could analyze and isolate behavioural tendencies across multiple patients and patterns in the cause or development of behaviour could be determined. This would permit the physician to "find and understand and apply those fundamental biological principles, which psychiatry is so eagerly in search of at present."[27] It is evident that Meyer and the Phipps staff were active in communicating his ideas through the specialty's major publication so that asylum physicians elsewhere could learn and adopt his scientific methods. Similar to the practices of other specialties, this Meyerian methodology granted psychiatrists the ability to make more accurate psychopathological diagnoses of patient disorders, while this data signalled which treatments would be most effective for each patient. These methods and techniques aided psychiatry in becoming a medical science and propelled the field further towards psychiatric normalization.

Within Meyer's first decade at Johns Hopkins, psychobiology and his scientific program were finding an audience across much of the North American psychiatric community. Yet, as Lamb insists, Meyer continued to struggle against the "reductive and dualistic impulses" of other physicians.[28] To combat his opponents and bolster the likelihood of psychiatry's normalization, Meyer contended that mental illness had to be medicalized.[29] Of course they may need specialized treatment, but Meyer recognized that care for the mentally ill should be "free of the old traditional discriminations and of any reinforcement of the notion of stigma" which plagued the mentally ill.[30] If Meyer

[26] Edward J. Kempf, "The Behavior Chart In Mental Diseases," *American Journal of Psychiatry* 71:4 (April 1915): 761.
[27] Kempf, "The Behavior Chart In Mental Diseases," 761.
[28] Lamb, *Pathologist of the Mind*, 96.
[29] Pressman, *Last Resort*, 20.
[30] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 343.

was to reorder the disordered thoughts and behaviours of his patients, he needed them to believe they were curable. At the Phipps clinic it was crucial for patients to acknowledge they were not resigned to an asylum. Instead they were taught their condition was an illness like that of the physically ill and that they deserved treatment in a modern hospital setting with attentive staff and expert psychiatrists.[31] Meyer justified this outlook in 1913 at the opening of the Phipps Clinic. He stated before the assembled crowd, "a psychiatric clinic must create standards of how to spend a day and perhaps weeks in a way in which a mind can find itself again."[32] At the Phipps, Meyer wanted to show patients that "so-called insanities are not so different from so-called nervousness," and that even mundane mental troubles were worthy of psychiatric treatment. For Meyer, psychiatrists had to examine the entire patient, including their anatomy, and psyche, as well as the conditions in their living environments. Consequently, psychiatrists had to prove to patients "that any kind of mental disorder receives very intense and well-directed work, and not merely asylum care and shelter."[33] This required the mentally ill to be treated medically in the same way that a somatic physician aimed to diagnose and cure patients.

Shorter adds that Meyer medicalized the treatment of insanity in a way that went beyond Kraepelin and other Germans. Throughout much of asylum history, patients were not simply admitted to institutions, they were often legally committed. The procedure usually required that a mentally ill person was assessed by at least two "respectable physicians," and if they agreed on the patient's condition then the patient

[31] Lamb, *Pathologist of the Mind*, 101-102, 163
[32] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 347.
[33] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 347, 348, 357.

was certified insane.[34] As Meyer argued, certification only added to the shame brought upon the mentally ill, and it often acted as a barrier which prevented families or individuals from seeking medical attention earlier.[35] When the Phipps Clinic opened, Meyer intended to have most, if not all patients arrive in an ambulance or of their own volition, "not in handcuffs" or "under a certificate."[36] Meyer wanted new patients to see that the Phipps admission ward was "indistinguishable from one of the general wards of the Johns Hopkins Hospital" so that they would perceive their condition as being similar to a physical illness.[37] Additionally, Meyer welcomed all from the acute and curable to the severe and chronic, but only "as long as the integrity of the therapeutic experiment remained intact and the safety of other patients was maintained."[38] Of the utmost significance however was that the Phipps Clinic was designed so that patients felt they were being treated in a general hospital and that their conditions were not stigmatized.[39]

Yet if psychiatrists were to be successful in helping patients, Meyer recognized that rural asylums and the certification system were not suited for the timely treatment of patients when their conditions were still acute. Meyer proposed the clinic as a way to catch patients in the earlier, more curable phases of their disorder, and for patients to be seen closer to their home community. As Meyer stated in 1913 before the International Congress of Medicine in London, with less severe cases, their treatment "can be fulfilled by outpatient departments and dispensaries."[40] With hospital psychiatric wards, patients

[34] Rothman, *The Discovery of the Asylum*, 134.
[35] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 362.
[36] Shorter, *A History of Psychiatry*, 111.
[37] Lamb, *Pathologist of the Mind*, 124-125.
[38] Lamb, *Pathologist of the Mind*, 194.
[39] Lamb, *Pathologist of the Mind*, 101-102, 112.
[40] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 360-361.

"can be tided over difficult periods or be started on adequate treatment without an official declaration of insanity."[41] With this objective, Meyer reasoned that patients requiring inpatient care should be directed towards urban general hospital psychiatric clinics. Meyer also argued that urban psychiatric clinics gave innumerable advantage to psychiatrists. With their urban location, clinics granted physicians the opportunity to see mentally ill patients nearer their own homes and local hospitals.[42] Not only was this beneficial for the well-being of patients, but it helped Meyer in developing a closer relationship with the community and patient families. This facilitated gathering more information about their home life, the history of their condition, and the epidemiological factors which might affect entire communities. Meyer suggested this would create more cohesion between psychiatrists and somatic physicians because they would be physically closer to one another. And if care was moved into urban clinics, then patients "may need a few days or weeks of rest and setting-right in a general hospital."[43] This indicates that in Meyer's vision for psychiatry, general hospitals and somatic physicians had to become more open to receiving mentally ill patients.

Since Meyer's speeches were circulated through the *AJP*, these reform ideas spread throughout the psychiatric community. From the 1913 onward, other psychiatrists began advocating for a similar approach in the treatment of the mentally ill. In his 1922 presidential address for the newly named American Psychiatric Association (APA), Barrett suggested that general hospitals "should have psychiatric services co-ordinated

[41] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 360-361; Lamb, *Pathologist of the Mind*, 116-118.
[42] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 360-361; Lamb, *Pathologist of the Mind*, 111, 123.
[43] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 332.

among their medical specialties," and that facilities for the examination and treatment of psychiatric disorder be as readily available to these patients "as those for medical or surgical conditions."[44] As Barrett indicated, there was still an "urgent" need for more psychiatric clinics because asylums could not offer the same treatment to acute cases.[45] Additionally, general hospital psychiatric services brought his field into closer contact with somatic specialties and this was of "inestimable" value to the community.[46] Canadian psychiatrists quickly saw the benefits of psychiatric clinics as well. In 1920, Gordon S. Mundie of McGill University explained that an outdoor outpatient psychiatric clinic had been established at the Royal Victoria Hospital in Montreal. Mundie stressed that these clinics played a crucial role in the community as they strengthened relationships between psychiatrists, general practitioners, and general hospitals.[47] As Barrett and Mundie show, both in the United States and Canada, psychiatrists were advocating for psychiatric clinics, and outpatient services. Furthermore, Walkup writes that Meyer influenced "the popular reform movement" in psychiatry "including the movement toward the general hospital."[48] According to his article Meyer was one of the American leaders who argued most convincingly for psychiatric wards being established in general hospitals. Through his student Barrett and even the distant Allan and Mundie, it can be seen how Meyer's reform ideas on general hospital psychiatric clinics expanded across the United States and Canada.[49]

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[44] Albert M. Barrett, "The Broadened Interests of Psychiatry," *American Journal of Psychiatry* 2:1 (July 1922): 5.
[45] Barrett, "The Broadened Interests of Psychiatry", 5.
[46] Barrett, "The Broadened Interests of Psychiatry", 5.
[47] Gordon S. Mundie, "The Role of the Psychiatric Clinic in the Community," *Canadian Journal of Mental Hygiene* 2:3 (October 1920): 237-238.
[48] Walkup, "The Psychiatric Unit Comes to the General Hospital", 13-14.
[49] Walkup, "The Psychiatric Unit Comes to the General Hospital", 13-14.

Meyer's vision for the "new psychiatry" was slowly coming to fruition, yet psychiatrists still had to convince other physicians that gaining experience with the mentally ill was necessary. To achieve this end, Meyer supported the proliferation of his psychiatric teaching throughout North American medical schools. This was another reform idea which led to the further assimilation of psychiatry within conventional medicine.[50] Before the twentieth century, Lief writes "Not a single medical school in the West at this time afforded facilities for the practical study of mental disease."[51] Dowbiggin also describes that there was no formal psychiatric curriculum in any medical school on the continent.[52] As Kansas City physician John Punton wrote in 1904, the average physician until recently knew nothing of psychiatry, but "even to-day its study is greatly neglected by many of our medical schools and colleges."[53] To remedy the situation Henry Hurd, director of Johns Hopkins Medical School, contended that the most effective method for preventing mental illness "should be a better recognition of psychiatry in the curriculum of every medical school."[54] He outlined that most physicians were unable to detect mental illness in its early stages, and they were not capable of offering treatment of mental disorders because "sufficient practical instruction was not given in medical schools."[55]

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[50] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 406; Pressman, *Last Resort*, 20; Pressman, "Essay Review: Psychiatry and Its Origins", 137.
[51] Alfred Lief, "Action at Kankakee," in *The Commonsense Psychiatry of Dr. Adolf Meyer*: *Fifty-Two Selected Papers, Edited with Biographical Narrative by Alfred Lief*, (New York, Toronto: McGraw-Hill Book Company, McGraw-Hill Series in Health Science, 1948), 49.
[52] Dowbiggin, *Keeping America Sane*, 4.
Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era London, ed., Andrew Scull (London: London: Athlone Press, 1981),
[53] John Punton, "The Trend of Modern Psychiatry and its Relation to General Practice," *Journal of the American Medical Association* 42:3 (16 January 1904): 156.
[54] Henry Hurd, "Psychiatry As A Part Of Preventive Medicine," *American Journal of Psychiatry* 65:1 (July 1908): 23.
[55] Hurd, "Psychiatry As A Part Of Preventive Medicine," 23.

As the AMPA attempted to bring psychiatric education into medical colleges, Meyer knew few institutions were capable of providing adequate training. For instance, Meyer criticized an unnamed Chicago medical college whose clinics and lectures on mental diseases were "of no value in itself and of harm to the students."[56] In his view, if the AMPA wanted to improve psychiatry in medical schools, they had to address the fact that there were not enough good teachers to supply the medical colleges.[57] At Johns Hopkins, Meyer got the opportunity to lead a medical school and psychiatry took its place amongst the other specialties. Aside from refining the education of psychiatrists, Meyer hoped others "may realize that indeed psychiatry is expected to bring a most important contribution to the rounding-off of a medical education and to the very foundations of general culture."[58] Along these lines, Meyer explained in 1913 that medical school psychiatry was to emulate the teachings of other specialties and to bring "such practical work near the student, exactly as is done in surgery, medicine, obstetrics, etc.—a chance for practical work and investigation."[59] For Meyer, psychiatric clinics modelled after the Phipps with links to medical schools allowed students and post-graduates "to obtain an intimate experience with the manner mental cases are studied and treated."[60] This gave physicians the ability to spot mental illness in its earliest stages, and it ensured all students acquired hands-on experience at the bedside of patients. Mental illness would be destigmatized in the process as more physicians gained experience with these patients and a greater interest in psychiatry.[61]

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[56] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 56.
[57] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 56.
[58] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 351.
[59] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 360.
[60] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 357.
[61] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 357.

As Meyer's ideas were circulated through journals, some of his colleagues migrated to new settings and brought Meyerian ideas along with them. One prominent example is Scottish psychiatrist Charles Macfie Campbell. Abraham explains that in 1904, upon Meyer's request, Campbell was brought into the New York Pathological Institute, and he eventually followed Meyer to the Phipps Clinic in 1913. After seven years with Meyer, Campbell became the chair at Harvard's new psychiatry department, and the director of the Boston Psychopathic Hospital. Campbell taught psychobiology and required his students to examine the complex reactions which occur in a patient's environment. He also adapted psychobiology to initiate "curricular reform that stressed the relevance of psychiatry for medical education in general."[62] In this example, it is apparent that Meyer's educational reform ideas took hold at Harvard, another of the nation's leading medical schools.

Aside from Campbell and the inner circle at Johns Hopkins, other notable psychiatrists in North America were receptive to Meyer's ideas. In his presidential address from 1923 to the APA, H. W. Mitchell pointed to Meyer specifically as one of the field's reformers and the main proponent of the "modern psychiatric standpoint" which saw each patient as a "distinctly individual, biological unit."[63] In following Meyer's theories, Mitchell explained through a quote from Meyer, that a psychiatry based on "brain speculation, auto-intoxications, focal infections, and internal secretions, could never have discovered" what the psychobiological approach has revealed through the use of the life history and the patients "ever-returning tendencies and situations."[64] Mitchell also stated that research must be conducted by "psychopathic clinics in connection with university

[62] Abraham, "Psychiatry in American Medical Education", 67-68, 75-76.
[63] H. W. Mitchell, "Presidential Address," *American Journal of Psychiatry* 3:1 (July 1923): 4.
[64] Mitchell, "Presidential Address," 4.

activities where the co-operation of all departments can be secured."[65] Clearly Meyer's ideas were being accepted by the elite in the field at a pivotal moment when psychiatrists were attempting to integrate more fully into the medical mainstream.

Part of the reason why medical schools were more willing to incorporate psychiatry into their institutions was due to a wave of standardization which washed over North American medicine in the first decades of the twentieth century. As Rosenberg explains, the Carnegie Foundation — one of American's leading philanthropic organizations — placed doctor Abraham Flexner in charge of an investigation of medical education across the continent in 1910. Flexner, himself a Johns Hopkins graduate, favoured institutions with an orientation towards clinical medicine. When his report was published, he stressed that there must be a "closer integration of hospital, medical science, and medical education."[66] With his ties to Johns Hopkins, the institution was held up as the model on which "practically all of Flexner's recommendations for other centers were based."[67] Flexner regarded psychiatry as a sub-standard specialty, but as historians Frank Stahnisch and Marja Verhoef describe, Meyer's approach balanced "the Flexnerian demands for rigorous laboratory-based training in medicine with certain nonreductionist views inherent to psychiatry and mental health care."[68] With Flexner's reliance on Johns Hopkins as the archetypal medical school, when Meyer was hired to be its head of psychiatry, it signalled to other physicians and psychiatrist's that Meyer's methods were acceptable by Flexnarian standards.[69]

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[65] Mitchell, "Presidential Address," 6.
[66] Rosenberg, *The Care of Strangers*, 209-211, 325.
[67] Michael Bliss, *The Making of Modern Medicine: Turning Point in the Treatment of Disease* (Toronto: University of Toronto Press, 2011), 41.
[68] Stahnisch, Verhoef, "The Flexner Report of 1910," 5.
[69] Stahnisch, Verhoef, "The Flexner Report of 1910," 1, 2, 5.

Within a few years, Meyer's first students were hired by university departments of psychiatry and they opened clinics modeled on the Phipps. In these clinics, Meyer's students used his pathological approach of researching mental disorders as well as his "instrumentalist concept of psychobiological reactions."[70] Each clinic subsequently included both inpatient and outpatient services, and they became laboratories within which to study and treat mental disorders through "clinical investigation and medical intervention."[71] The Phipps model was so successful that AMPA president Henry C. Eyman commented on the proliferation of psychiatric clinics in his 1920 address. Eyman supported their spread and declared that the quest for mental health was "greatly aided by the psychiatric clinics which can now be found in many of our cities, especially eastern cities."[72] Around 1925, there were nine clinics in Pennsylvania, twenty-five in New York, and thirty-three in Massachusetts.[73] As Shorter describes, these clinics helped to "erase the boundary between the closed asylum and the community" with psychiatrists now moving into urban centers closer to where most patients lived.[74]

In these first few decades of the twentieth century, psychiatrists acknowledged that Meyer's methods provided their specialty with the necessary tools to end its professional isolation within the medical community. Jointly, all of his reform ideas were reshaping the entire field from London to California. Yet another component in his reform strategy required the involvement of society as a whole. This was his concept of mental hygiene. In many ways this idea was conceived in part due to the involvement of patient reformers. In

[70] Lamb, *Pathologist of the Mind*, 129.
[71] Lamb, *Pathologist of the Mind*, 162.
[72] Henry C. Eyman, "Presidential Address," *American Journal of Psychiatry* 77:1 (July 1920): 3.
[73] Grob, *Asylum to Community*, 239-240; Shorter, *A History of Psychiatry*, 230.
[74] Shorter, *A History of Psychiatry*, 230-231.

September 1907, Clifford Beers paid Meyer a visit to seek the psychiatrist's advice on establishing an advocacy society that would work to improve conditions in asylums. Meyer instead proposed that a "hygiene movement with a sociological tie-up" would be better way to achieve these goals. Beers eventually agreed and by February 19, 1909, the National Committee for Mental Hygiene (NCMH) was founded. Beers himself stated years later that it was Meyer "who suggested 'mental hygiene' as the words to use in naming the National Committee and the movement."[75] The term hygiene was meant to illustrate to the public that mental illness was not purely an issue for the severely insane, but that everyone should be concerned about their mental health.[76] As Dowbiggin wrote, this was a defining moment in the history of mental health. The goal was no longer to cure mental disease. Instead the NCMH would promote mental health.[77]

Beers may have been the public figure of the movement, but Meyer's influence guided the direction and goals of the NCMH. At their first meeting, Meyer believed that for change to occur, psychiatrists, physicians, and other experts should control the committee. As Meyer envisioned, its purpose was to promote psychiatric research, to pressure medical schools to include psychiatry in their curriculums, to educate the public on mental illness, and to survey institutions to find the prevalence of mental illness in society.[78] Although Beers grew disgruntled with the way in which Meyer and other psychiatrists came to dominate the NCMH, the Meyerian reform idea of mental hygiene and its advocacy movement did much to shape mental health care in the twentieth century.

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[75] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 280-281, 312.
[76] Gerald N. Grob, *Mental Illness and American Society, 1875-1940* (Princeton, N.J.: Princeton University Press, 1983), 154.
[77] Dowbiggin, *The Quest for Mental Health*, 94-95.
[78] Dowbiggin, *The Quest for Mental Health*, 94-95.

In Barrett's presidential address from 1922, titled "The Broadened Interests of Psychiatry," he explained that the specialty was moving beyond "institutional work," and "private practice."[79] Their new role concerned mental disorders throughout society and psychiatrists were meant to take action wherever mental illness was "disturbing the smooth course of social progress."[80] No longer were they in charge of dealing with incurable paupers in state asylums. Their new purview made them responsible for the public's mental health as a whole. Through Meyer's concept of mental hygiene and the knowledge that mental illness was pervasive in society, the psychiatrist's authority was magnified in North American medicine. These specialists were now granted more political, social, and medical power than was previously thought possible when the century began.[81] Yet, without other events and actors outside of psychiatry, it is possible that Meyer's reform agenda may not have succeeded in reshaping the specialty.

The first and most significant event was World War I. Since coming to America, Meyer had developed the notion that mental disorders ran across a spectrum and that the mental state of any individual could become disturbed.[82] Dowbiggin explains that this theory of a "fine line between psychological normality and abnormality received a huge boost" as a result of the Great War.[83] The conflict shaped global economics and politics, but within psychiatry, the war transformed the field after 1918. With its modern military weapons, the horrors of trench warfare, and the global scale of the conflict, thousands of soldiers experienced combat related mental distress, and their psyches were damaged by the

[79] Barrett, "The Broadened Interests of Psychiatry", 3.
[80] Barrett, "The Broadened Interests of Psychiatry", 13.
[81] Pressman, *Last Resort*, 27; Dowbiggin, *Keeping America Sane*, 11.
[82] Lamb, *Pathologist of the Mind*, 101.
[83] Dowbiggin, *The Quest for Mental Health*, 95.

war. Famously, the name given to the psychological disorders which soldiers suffered became known as "shell-shock." The condition itself was characterized by "fear, paranoia, bouts of uncontrollable crying, paralysis of the limbs, mutism, tremors, twitches, nightmares, delusions, and sleeplessness," to name only the most prevalent symptoms.[84]

At the beginning of war, many of these soldiers were seen as cowards and malingerers. If a soldier fell ill with shellshock it was thought to be a result of their own "moral failing."[85] Yet as these causalities accumulated it became clear to psychiatrists, neurologists, and psychologists that previous understandings of mental illness were flawed. Traditionally most practitioners in these fields thought that mental illness usually formed in people who had a familial history of such afflictions. The war emphatically proved these notions to be false. Even fit young men with no supposed genetic hereditability for mental illness were at risk of developing a psychological disorder if enough stress and trauma was forced upon them. Many mental health practitioners began to comprehend the consequences of this realization. As Meyer proposed, this meant mental disorders could form in any individual, and everyone in society was vulnerable given the right combination of environmental and social pressure.[86] Psychologist Cyril Burt outlined the wider repercussions when he wrote that in the military hospitals, patients with shellshock often had symptoms which resembled those of other well-known psychoses. When given basic psychotherapy, the disorders which these soldiers had proved to be quickly curable. It then became apparent to Burt that "much of what had been considered abnormal might be

[84] Stefanie Linden, *They Called it Shell Shock: Combat Stress in the First World War* (Warwick, Eng.: Helion and Company Ltd., 2018), 41-43; Dyck, Deighton, *Managing Madness*, 34.
[85] Dyck, Deighton, *Managing Madness*, 34.
[86] Dowbiggin, *The Quest for Mental Health*, 95; Lamb, *Pathologist of the Mind*, 248.

discovered in the mind of the average man."[87] Because of World War I and the experiences of shellshocked soldiers as well as the physicians who treated them, this evidence proved the distinction between mental wellness and illness was not based purely on heredity.[88]

Additionally, over the course of the war effort, psychiatrists, neurologists, and other mental health professionals were given a greater role in the medical care of soldiers. As they bore these responsibilities, the public and governments started to acknowledge their importance as medical practitioners. American psychiatrist Edward A. Strecker noticed this in 1919 when he wrote that psychiatrists during the war "were not confronted by a wall of prejudice, pessimism, indifference, lack of resources and means which block and discourage" their work.[89] Americans seemed to grasp the importance of mental health because they were forced to consider "the human problems which have been defined and emphasized by the war."[90] Moreover, Brown describes that like no event before it, the war was as a catalyst which led to psychiatry's professionalization as a medical specialty. The old image of psychiatrists as "mad-doctors" resigned to insane asylums was discarded by a new generation of "neuro-psychiatric specialists" who could effectively provide therapy to shell-shocked soldiers and other mental disorders. Owing to their proven abilities in treating these various war neuroses, the once lowly psychiatrist gained greater professional admiration. In the

[87] Elaine Showalter, *The Female Malady: Women. Madness, and English Culture, 1830-1980* (New York: Pantheon Books, 1985), 73.
[88] Dowbiggin, *The Quest for Mental Health*, 95.
[89] Edward A. Strecker, "Experiences In The Immediate Treatment Of War Neuroses," *American Journal of Psychiatry* 76:1 (July 1919): 69.
[90] Strecker, "Experiences In The Immediate Treatment Of War Neuroses," 69.

medical world the specialty was finally attaining more respect than homeopaths and spa-doctors.[91]

As thousands of soldiers returned home with mental scars, the public began to perceive mental health differently. For instance, asylums were no longer viewed as an acceptable means of treatment for people suffering from these afflictions, especially war veterans, though many still endured stigma and societal rejection.[92] With regards to treatment, neuropsychiatrists were pressured by the military to figure out ways to get soldiers back on the front lines. Working in these circumstances led practitioners to the conclusion that, at least in the short term, the most effective way to deal with these disorders was to provide treatment immediately after the first signs of mental distress appeared.[93] Most significantly, as Bond remarked in 1921, interest in mental disorders and mental health rose tremendously after the war. According to Bond it was now difficult to find anyone who would argue that the "mental health of the nation is of less moment to it than its physique."[94] As Lief wrote, the war "both sped up and diverted" psychiatry's course, but it proved the merit of Meyer's theories.[95] With Meyer's ideas gaining further clinical efficacy as a result of the war, his reforms acquired more devotees "beyond U.S. borders."[96]

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[91] Thomas E. Brown, "Shell Shock in the Canadian Expeditionary Force, 1914-1918: Canadian Psychiatry in the Great War," in *Health, Disease, and Medicine: Essays in Canadian History*, ed., Charles G. Roland, (Toronto: Clarke Irwin, 1984), 322; Mark Humphries and Kellen Kurchinski, "Rest, Relax, and Get Well: A Re-Conceptualisation of Great War Shell Shock Treatment," *War & Society* 27:2 (2008): 89-110.
[92] Dyck, Deighton, *Managing Madness*, 34; Fiona Reid, "'his nerves gave way': Shell shock history and the memory of the First World War in Britain," *Endeavour* 38:2 (June 2014): 97-100; Terry Copp and Mark Osborne Humphries, *Combat Stress in the 20th Century: The Commonwealth Perspective*, (Kingston, On: Canadian Defence Academy Press, 2010), 101.
[93] Dyck, Deighton, *Managing Madness*, 34.
[94] Bond, "Presidential Address", 405.
[95] Meyer, The Commonsense Psychiatry *of Dr. Adolf Meyer*, 449-451.
[96] Dowbiggin, *The Quest for Mental Health*, 94.

Under these circumstances, Meyer's theories on mental hygiene were quickly embraced in Canada by C. K. Clarke, as well as a young physician with no training in psychiatry named Clarence Hincks. According to Shorter, due to his interest in mental hygiene and eugenics, Clarke asked Hincks in 1914 to work for him at the Toronto General Hospital in the outpatient department's "Feeble-Mindedness Clinic." In 1917, Hincks visited the New York offices of the NCMH and, with Clarke, established the Canadian National Committee for Mental Hygiene (CNCMH) the following year. Almost instantly the CNCMH became Canada's foremost advocacy group for mental hygiene.[97] The committee then turned into a conduit for Meyer's reforms, bringing his ideas to a Canadian audience. The CNCMH spread awareness of mental illness and its first signs, as well as the need to swiftly treat patients in the acute stages of disorder. They also emphasized that care had to be moved from rural asylums to urban general hospitals, and that psychiatric clinics must be connected to university medical schools.[98] Furthermore, other connections between the Canadian and American committees can be confirmed as Hincks and Meyer both attended the AMPA's annual meeting in 1918.[99] Hincks later acknowledged Meyer's stature in the field when in 1944 he wrote that the now retired professor was part of American psychiatry's "nucleus."[100] When observed collectively, the formation of the CNCMH, the use of "mental hygiene" in the Canadian committee's name, and the adoption

[97] Shorter, *Partnership for Excellence,* 357-358.
[98] Dyck, Deighton, *Managing Madness,* 36.
[99] "Proceedings of Societies, American Medico-Psychological Association, Proceedings of the Seventy-Fourth Meeting," *American Journal of Psychiatry* 75:2 (October 1918): 251-295.
[100] Clarence M. Hincks, "What Of The Future For American Psychiatry?" *American Journal of Psychiatry* 100:6 (1944): 195.

of NCMH policies all illustrate that Meyerian psychiatry was extending its influence into Canada especially through the mental hygiene movement.[101]

As Meyer's ideas gained currency amongst psychiatrists, they also piqued the interests of other reformers. As Pressman explains, for lasting changes to take hold in psychiatry, the specialty required "large investments of capital."[102] After decades spent donating to scientific charities, the Rockefeller Foundation — the largest private philanthropic organization in the United States — restructured in 1929 and made the promotion of the "well-being of mankind" its mission. To carry out this broad objective, the Rockefeller foundation now chose to fund medical innovations, and psychiatry became its central focus. The Rockefeller trustees realized that to improve medicine they must begin by ameliorating "the most backward, the most needed, and the most probably fruitful field in medicine."[103] They aimed to invest in "the creation of entire departments of psychiatry and new research institutes."[104] The foundation presumed that this was the best way to train more psychiatrists and generate innovation through research. At that time Alan Gregg, the Foundation's director, wanted an institution and a psychiatric approach to serve as a model. Soon he was led to Meyer whose "expansive vision" for psychiatry appealed most to the Foundation's goals.[105] Although it took decades and millions of dollars from the Rockefeller Foundation, Gregg eventually pushed the Meyerian approach into North American medical schools by refabricating psychobiology into the more laboratory oriented "psychosomatic" medicine. The combination of philanthropic investment with

[101] Dowbiggin, *The Quest for Mental Health*, 94; MacLennan, "Beyond the Asylum", 7-19.
[102] Pressman, *Last Resort*, 30.
[103] Pressman, *Last Resort*, 30.
[104] Pressman, *Last Resort*, 30-31.
[105] Pressman, *Last Resort*, 32.

greater public interest in mental health following World War I combined at the right moment to thrust Meyer's reform strategy forward in the twentieth century.[106] Together these factors brought psychiatry out of its professional isolation and aided in normalization the specialty within somatic medicine.

Despite the fact that Meyer's theories began to dominate North American psychiatry, he still had trouble convincing other physicians of his theories. For example, in 1914 Meyer taught a class at Johns Hopkins and found most students were unwilling to accept idea that human behaviour could be a part of modern medicine. According to Meyer, these students had little interest in what could not be "observed in a test tube or under a microscope."[107] The views of his students illustrate that materialism dominated medicine as students were often skeptical of psychiatry and the psychological basis for mental disorders. By 1917, Meyer was reaching more students. He wrote that, when working with surgeons or internists, some students reported to Meyer that patients on these wards suffered from mental disorders, but the professors in charge felt there was "nothing the matter with them."[108] Meyer's ideas were clearly connecting with students as they engaged more with psychiatry, but even the faculty at Johns Hopkins still held outdated views of the specialty and mental illness.

Meyer and other leaders in the field decided to establish a Division of Psychiatric Education of the National Committee for Mental Hygiene in order to prioritize proper training. Meyer acted as honorary president and chairman of the division advisory

[106] Pressman, *Last Resort*, 30-34, 43-44.
[107] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 372.
[108] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 410.

committee, but it was Franklin G. Ebaugh who became its director.[109] In 1932, Ebaugh presented his research before the Section on Nervous and Mental Diseases at the 83rd Annual Session of the American Medical Association (AMA). In the address titled "The Crisis in Psychiatric Education," Ebaugh mentioned that every medical school he visited purported to have facilities for the teaching of psychiatry, but there were obvious differences in their curricula and in the quality of education being given. Of sixty schools, Ebaugh stated that eleven taught psychobiology, while another 26 taught some form of preclinical medical psychology or psychopathology. Psychiatric education was rapidly evolving, but most universities still "paid little attention to the teaching of psychiatry."[110] The consequence was that most students were not interested in psychiatry and they failed to see that psychiatry was a fundamental aspect for "all medicine."[111] In a survey of deans and professors, Ebaugh found that many criticized the specialty for its lack of integration, isolation, poorly trained personnel, varying terminology, inexactness, and therapeutic inefficiency, although some were experiencing "an awakening of interest in problems of behaviour which cannot help but be significant in improving the work in all fields."[112]

To resolve this crisis Ebaugh and the advisory committee made a series of recommendations that were intended to amalgamate psychiatry into "the four major divisions of the medical curriculum."[113] The list included reforms such as the creation of psychotherapeutic clinics and institutes of research in universities, closer links with public health and preventive medicine, the opening of extramural clinics and community programs

[109] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 377.
[110] Franklin G. Ebaugh, "The Crisis in Psychiatric Education, Chairman's Address," *Journal of the American Medical Association* 99:9 (27 August 1932): 703.
[111] Ebaugh, "The Crisis in Psychiatric Education, Chairman's Address," 703.
[112] Ebaugh, "The Crisis in Psychiatric Education, Chairman's Address," 705.
[113] Ebaugh, "The Crisis in Psychiatric Education, Chairman's Address," 706.

for the mentally ill, the elimination of custodial hospitals as isolated units, and board certification for psychiatrists. First on the list of objectives however was "Complete integration under the same roof: psychiatric beds in the general hospital."[114] In concluding his address, Ebaugh said the crisis was a symptom of the larger emergency facing the whole of medicine as changing attitudes were transforming the relationship "of the physician to society."[115] As Ebaugh reasoned, if medicine was to solve this problem, it was in desperate need of psychiatry's help. If psychiatric education were to improve, then it would assist all of the medical specialties in developing more socially useful and therapeutically efficient physicians. The end result would be that in applying psychiatry to their practices, physicians would begin to treat the whole patient including "mind as well as a body."[116] With these recommendations, a clear pathway was marked for medical schools to follow so that psychiatry could merge with somatic medicine. Additionally, the address is proof that Meyer's reform strategy was agreed upon by the leaders of American psychiatry as being the way to achieve normalization.

Following the report, the psychiatric community attempted to devise board certifications. Yet as Abraham writes, a "lack of uniformity" characterized the specialty as different boards, colleges, and societies all existed at once.[117] In 1933, the NCMH, the APA, the Section on Nervous and Mental Diseases of the AMA, and the American Neurological Association (ANA) met to discuss board certification. All parties eventually agreed that with the "overlap between the fields of neurology and psychiatry," they would

[114] Ebaugh, "The Crisis in Psychiatric Education", 705-707.
[115] Ebaugh, "The Crisis in Psychiatric Education", 707.
[116] Ebaugh, "The Crisis in Psychiatric Education", 705-707.
[117] Abraham, "Psychiatry in American Medical Education," 78.

only need a single board. Soon the American Board of Psychiatry and Neurology came into being with four members coming from each association, and Meyer served as one of the APA's board representatives.[118]

Even with board certification and cohesion between these associations, other physicians still openly challenged psychiatry. In 1938, the American Association for the Advancement of Science held a symposium on the subject of mental health. The introductory speech was delivered by Thomas W. Rivers, a physician at the Rockefeller Institute. Rivers criticized psychiatrists for their isolation and for "offering an 'inundation of words' instead of a scientific discipline."[119] In response, Meyer wrote that Rivers was a "rehearse of anachronistic tradition," and that such views only proved his ignorance towards psychiatry.[120] For Meyer, many of the speakers at the symposium thought that a mentally ill patient was a host for these diseases, as though they were infected with mental illness, and most ignored Meyer's notion that patients were the "participant and center of the difficulty itself."[121] In these last years of his career, Meyer hoped that with greater recognition of the psychobiological origins of mental disorders, then other specialties would observe the interconnections between their specific physiological focus, and psychiatry's ability to help all disciplines see their patients as whole individuals.[122] Once this concept was grasped by the medical establishment, and with Meyer having laid the

[118] Abraham, "Psychiatry in American Medical Education", 78; Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer,* 377.
[119] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 558.
[120] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 558.
[121] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 559.
[122] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 558-559.

foundation of reform, psychiatry was able integrate into general hospitals and medical schools more easily, and normalization would be achieved.[123]

In 1941, at the age of 75, Meyer retired from Johns Hopkins just as fresh signs of psychiatry's integration into somatic medicine were starting to appear.[124] More than ever general hospital inpatient wards, outpatient clinics, and community care clinics were being developed across America, and many were connected to university medical schools. With the founding of each new facility, normalization was carried one step further. Though Meyer's role in the vanguard of psychiatry's reform movement diminished, his ideas were brought forward by his students and younger colleagues. To show how the process of normalization unfolded, it helps to assess the statistics provided by Thos J. Heldt. In 1939, Heldt wrote that of the 4309 general hospitals in the U.S., only 112 had departments "for mental patients."[125] North of the American border, Heldt calculated there were only four full-fledged psychiatric wards among Canada's 458 general hospitals.[126] Then in 1942, Ebaugh and Charles Rymer edited a new report on medical school education. They found that of 67 schools in the United States and Canada, 27 classified their psychiatry program as being based in psychobiology. The runner up was medical psychology which 13 institutions aligned with, while 11 said they taught psychiatry.[127] Evidently psychiatry was making progress, but there was much distance to cover before normalization was to be reached.

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[123] Pressman, *Last Resort*, 45-46.
[124] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 562.
[125] Thos J. Heldt, "Psychiatric Services in General Hospitals," *American Journal of Psychiatry* 95:4 (January 1939): 866.
[126] Heldt, "Psychiatric Services in General Hospitals," 866.
[127] Abraham, "Psychiatry in American Medical Education", 77.

In the 1940s, Meyer's theories and approach to psychiatry gained an added boost because of World War II. As Grob illustrates, this war reaffirmed for psychiatrists that environmental and combat stress caused mental disorders, and that early treatment in "noninstitutional settings produced favorable outcomes."[128] Furthermore, as Walkup suggests, because of the reforms which Meyer's generation brought to the specialty, psychiatrists during World War II increasingly recognized the utility of general hospital psychiatric wards. Ebaugh even argued that it was medically negligent and fiscally wasteful for American society to continue the use of asylums instead of general hospitals. He reasoned that if patients were seen promptly in general hospitals, then chronic cases would not develop, and the nation could prevent "over 100,000 persons with psychiatric illness" from being sent to mental institutions annually.[129] Another outcome of the war for psychiatry was that physicians grew closer to other specialists after it was demonstrated that they were capable of collaborating with somatic physicians within general hospitals.[130] The normalization of psychiatry was another step closer to becoming a reality, though the road towards integration was a long one.

In the post-war years, new studies were conducted on the incorporation of psychiatry into North American general hospitals. Authors A. E. Bennett, Eugene A. Hargrove, and Bernice Engle, wrote an article for the *JAMA* in 1951, entitled "Psychiatric Treatment in General Hospitals." In their study, the authors surveyed the American College of Surgeons, and the American Hospital Association, as well as hospital administrators and interested physicians in institutions believed to have psychiatry departments. Once the data

[128] Grob, *From Asylum to Community*, 5.
[129] Walkup, "The Psychiatric Unit Comes to the General Hospital", 15.
[130] Walkup, "The Psychiatric Unit Comes to the General Hospital", 15.

was compiled, they noted that of 574,683 total beds in 4,761 U.S. general hospitals, there were only 24,000 psychiatric beds. This equalled four percent of all general hospital beds despite patients with emotional disturbances accounting for at least 25 percent of all general hospital admissions. Moreover, there were 328 general hospitals in the U.S., that were reported to offer psychiatric services. In Canada there was only 509 psychiatric beds out of 12,346, or four percent, though nine hospitals were planning expansions. Administrators were still reporting that other specialists did not want psychiatric patients in general hospitals as some feared that "suicidal and homicidal dangers are always imminent, and noisy patients are the cause of complaints."[131] Others argued that psychiatric patients would be a financial drain.[132] Based on their findings however, the authors recommended that most hospitals could accommodate a 25-bed psychiatric department. As an example, the authors pointed to the Herrick Memorial Hospital in Berkeley California which was remodelled to these specifications, and the unit managed to turn a profit after it was built. Significantly, an administrator at Herrick said, "Our psychiatric department is performing a distinct service in the hospital and community" and all hospital departments were becoming more aware of psychiatric problems. Not only was the stigma fading for patients and psychiatrists at Herrick, but the department "more than paid its cost of operation."[133]

With regards to educating other physicians in psychiatry, Bennett, Hargrove, and Engle, proposed that these wards helped all specialists in a general hospital acknowledge "the role of emotional factors in many illnesses."[134] General hospital psychiatric units were

[131] A. E. Bennett, Eugene A. Hargrove, and Bernice Engle, "Psychiatric Treatment in General Hospitals," *Journal of the American Medical Association* 147:11 (10 November 1951): 1021.
[132] Bennett, et al., "Psychiatric Treatment in General Hospitals", 1019-1021.
[133] Bennett, et al., "Psychiatric Treatment in General Hospitals", 1021.
[134] Bennett, et al., "Psychiatric Treatment in General Hospitals", 1021.

ideal environments for research as well as the teaching of medical students. Crucially the authors explained that students, young doctors, and nurses were seeing psychiatry in its proper perspective and all were learning the "importance of emotions in causing or contributing to many illnesses."[135] According to the authors, the use of general hospitals by medical schools to help teach psychiatry was a necessary "step in the right direction." Yet despite these obvious advantages, the survey data showed that out of 73 four-year medical schools in the U.S., 52 used general hospitals for psychiatric teaching, training and research, and only nine schools "used all clinical departments for teaching psychiatry to medical students."[136] In Canada's ten four-year medical schools, seven taught psychiatry in general hospitals, and only six provided "full psychiatric treatment service."[137] The authors stressed that because emotional factors comprised 25 to 50 percent of all hospital admissions, every general hospital had to add psychiatric inpatient units and outpatient clinics. Making these changes was critical if psychiatry and somatic medicine were to benefit from one another through closer contact and collaboration. Though there had been progress over the course of the century, the authors maintained that the general hospital had to become the key institutional setting for psychiatry.[138] As this article demonstrates, while total assimilation was far from complete by 1951, psychiatrists still thought the path forward was to be paved with the broader reform ideas developed by Meyer decades earlier.

[135] Bennett, et al., "Psychiatric Treatment in General Hospitals", 1022.
[136] Bennett, et al., "Psychiatric Treatment in General Hospitals", 1021.
[137] Bennett, et al., "Psychiatric Treatment in General Hospitals", 1022.
[138] Bennett, et al., "Psychiatric Treatment in General Hospitals", 1022-1023.

Over the course of the decade other psychiatrists put forward reform plans which contained many of Meyer's ideas. This came as no surprise to many in the field. As Meyer's obituarist Oskar Diethelm wrote for the *AJP* on March 17, 1950, the "Dean of American Psychiatry" had been the foremost proponent for the integration of his "clinic in the Johns Hopkins Hospital."[139] Through Meyer, psychiatric thinking "permeated other departments and formed the basis for the development of psychiatric activities in general hospitals."[140] Despite the deficient integration of psychiatry into all general hospitals and medical schools at that point, other prominent psychiatrists felt the specialty was making its way into the medical mainstream. Many who took this position pointed towards Meyer as the central influence in modern North American psychiatry. For instance, John Whitehorn, Meyer's successor at Johns Hopkins, wrote in 1957 that when foreigners visit American medical schools, one of the distinguishing features they observe is the "large role played by psychiatrists in medical education."[141] According to Whitehorn, the prototype on the continent for such teaching "was Adolf Meyer's course in psychobiology."[142] Furthermore, Meyer's collaborative approach with other fields and the view of the "patient as a person" had all become common in the teaching of medical students.[143]

By 1964 some psychiatrists were confirming that normalization was finally being achieved within general hospitals. At Georgetown University School of Medicine, in Washington D.C., psychiatrist Zigmond M. Lebensohn, examined the state of his discipline in the *Medical Annals of the District of Columbia*. In his article, Lebensohn described that a

[139] Diethelm, "In Memoriam Adolf Meyer, 1866-1950", 80.
[140] Diethelm, "In Memoriam Adolf Meyer, 1866-1950", 80.
[141] John C. Whitehorn, "American Psychiatry," *American Journal of Psychiatry* 114:2 (August 1957): 112.
[142] Whitehorn, "American Psychiatry," 112.
[143] Whitehorn, "American Psychiatry," 113.

"flourishing romance between American psychiatry and the American general hospital" had recently developed, and that the two were exhibiting all signs of "going steady."[144] Lebensohn explained that before 1945 only 176 general hospitals would admit psychiatric patients. Between 1951 and 1964 however, Lebensohn wrote that the number of general hospital psychiatric wards rose from 328 to over 800, and that more psychiatric patients were now admitted to these units than "all of the public mental hospitals combined." With the general hospital idea having gained such wide acceptance, Lebensohn wrote, it is "true that any general hospital designed without a psychiatric unit will be obsolete before it is finished."[145] According to the author, America was undergoing a revolution in the treatment mental illness, one which involved every physician, as asylums were being replaced by psychiatric wards in general hospitals.[146]

For Lebensohn, this was due to the new psychiatric treatment methods used in general hospitals such as somatic therapy, drug therapy, and brief psychotherapy. Yet part of this success rested in the general hospital becoming a "true community health center in the total network of community health services."[147] Overtime, thanks to the reform ideas put forward by Meyer, general hospitals became the locus of care for the mentally ill in the same way they had been for the physically ill. The general hospital psychiatric unit therefore existed as a "safety valve" in the community where all forms of mental illness could be treated in a familiar setting with the "absence of stigma, closeness to family and work, and continuity of psychiatric and medical care by the patient's family psychiatrist

[144] Zigmond M. Lebensohn, "American Psychiatry and the General Hospital," *Medical Annals of the District of Columbia* 33:2 (February 1964): 47.
[145] Lebensohn, "American Psychiatry and the General Hospital", 48.
[146] Lebensohn, "American Psychiatry and the General Hospital", 48.
[147] Lebensohn, "American Psychiatry and the General Hospital", 48.

and family physician."[148] With regards to psychiatry's normalization in mainstream medicine, Lebensohn argued that the general hospital was the only device which brought psychiatry "back to medicine."[149] At the same time, it permitted psychiatrists to bring their knowledge "to the medical fraternity."[150] He also mentioned other benefits which Meyer highlighted. These institutions allowed for "a healthy exchange of ideas and practices" between all physicians, while they made exceptional teaching environment for medical schools. In the end, Lebensohn assured readers that general hospital psychiatric units were "spearheading a true revolution in psychiatric care" especially with their rapid growth since World War II.[151] By the 1960s, some in the field were feeling strongly that psychiatry was normalizing.[152]

In Canada, there were also signs that psychiatry's position within the medical community was improving. That same year, the Department of Medical Economics of the Canadian Medical Association (CMA) issued their "Recommendations of the Royal Commission on Health Services." Of the department's 200 recommendations, mental health was listed as its second major priority after their suggestion that the Federal Government enter into agreements with the provinces and territories to provide "comprehensive, universal, provincial programmes of personal health services."[153] Regarding mental health, they advised that training grants be given to psychiatric students so that more of them could be trained. Medical schools were also to be provided with

[148] Lebensohn, "American Psychiatry and the General Hospital", 48-49.
[149] Lebensohn, "American Psychiatry and the General Hospital", 49.
[150] Lebensohn, "American Psychiatry and the General Hospital", 49.
[151] Lebensohn, "American Psychiatry and the General Hospital", 52.
[152] Lebensohn, "American Psychiatry and the General Hospital", 51-52.
[153] Department of Medical Economics, The Canadian Medical Association, "News and Views on the Economics of Medicine, Recommendation of the Royal Commission on Health Services," *Canadian Medical Association Journal* 91:5 (1 August 1964): 1.

funding to conduct courses in psychiatry for general practitioners with additional subsidies given to psychiatric research, as well as the evaluation of community mental health programmes. Most significantly, the department proposed that hospital construction grants should cover half the cost for psychiatric wards so they could be built in all general hospitals with over 100 beds.[154] At this point in time, even the Canadian Medical Association (CMA), the country's leading medical organization, made psychiatric reform one of its top priorities. These recommendations indicate that Meyer's reform ideas reached the Canadian medical establishment by the 1960s.

Additionally, in 1965, psychiatrists J. S. Tyhurst and A. Richman of British Columbia informed readers of *Canadian Hospital* that the patterns of psychiatric care were changing.[155] By the 1960s, three "patterns of care" were emerging for psychiatric patients. As the authors explained, the first "emphasized medical integration" or rather that psychiatric care was consolidating with "other forms of medical care in medical centres."[156] Comprehensive care was also developed. This ensured that patients could avail themselves of the full range of services that they may require during the course of their illness. Finally, care was being regionalized as the mentally ill could seek treatment closer to where they lived in general hospital psychiatric units. Statistically, Tyhurst and Richman outlined that between 1951 and 1956, the number of Canadian general hospitals with 100 or more beds with some form of psychiatric service "increased from 48 to 66%."[157] With psychiatric

[154] Department of Medical Economics, The Canadian Medical Association, "News and Views on the Economics of Medicine," 1-3.
[155] A. Richman and J.S. Tyhurst, "Psychiatric care in a general hospital," *Canadian Hospital* 42 (May 1965): 45.
[156] Richman, Tyhurst, "Psychiatric care in a general hospital," 45.
[157] Richman, Tyhurst, "Psychiatric care in a general hospital," 45.

beds, these figures rose from 318 in 1951 to 1331 by 1959.[158] The pair also provided insights which illustrate how these changes took place in the Vancouver General Hospital. In this 1600 bed facility, a psychiatric inpatient unit of 40 beds had been established, alongside outpatient, after-care, consultation, and emergency services, as well as a physical therapy unit, and the facility was used by the university medical school. With its urban location, the psychiatric unit became an integral part of the "internal hospital community," while it served the surrounding community.[159] Furthermore, the general hospital psychiatric services that Tyhurst and Richman described prove that Meyer's reform strategy was being executed in individual general hospitals, and that the specialty was ultimately normalizing within Canadian medicine.

To substantiate the notion that Meyer's reforms had international influence, it helps to briefly examine psychiatry in Britain. When Lebensohn, Tyhurst, Richman, and even the CMA were asserting that psychiatry was being incorporated into general hospitals, British physicians noticed a similar transformation was occurring in their country. In 1970, psychiatrists John M. Kellett and Alex G. Mezey noted that a policy of integration had been enacted whereby "all medical services in district hospitals" increased the need for cooperation between psychiatry and other specialties.[160] To understand the attitudes which somatic physicians held towards psychiatry, surveys were answered by 88 practitioners in six general hospitals. Remarkably, Kellett and Mezey found most specialists now rejected a "physical-psychiatric dichotomy."[161] The authors also insisted that the results were

[158] Richman, Tyhurst, "Psychiatric care in a general hospital," 45-46.
[159] Richman, Tyhurst, "Psychiatric care in a general hospital", 45-46.
[160] John M. Kellett and Alex G. Mezey, "Attitudes to Psychiatry in the General Hospital," *British Medical Journal* 4 (Oct 1970): 106.
[161] Kellett, Mezey, "Attitudes to Psychiatry in the General Hospital," 107.

"encouraging for the integration of psychiatric services into the general hospital," and that specialists had become more aware of the role which psychological factors play in patient health. Finally, Kellett and Mezey stated that "psychiatry need no longer consider itself outside the main stream of clinical medicine."[162] With psychiatry becoming more incorporated into these facilities it is evident that the field made tremendous strides towards integration over the course of the twentieth century. When observed through the lens of intellectual history, it was conclusively determined here that the reform ideas which Adolf Meyer developed and circulated ultimately led to psychiatry's normalization within the medical community by 1970.

After assessing Meyer's deep intellectual legacy it comes as a surprise to find that scholars have noted he was already being forgotten by the time psychiatry was normalizing.[163] To grasp his significance however, it is necessary to observe the way in which his peers and students remembered Meyer in the years after his passing. As just one example, in 1966 Ebaugh wrote a tribute and described many of Meyer's transformative ideas as having become "educated common sense to most psychiatrists."[164] Ebaugh asserted that Meyer "freed psychiatry from its dependency upon pathology," from brain-mind parallelism, and from meaningless classifications more than anyone in the American field. He did this by incorporating the ideas of American pragmatists, while healing "the mind-body schism in psychiatric thinking," and teaching the medical community to observe the patient as a whole person. Meyer's approach to psychiatric education was "extremely

[162] John M. Kellett and Alex G. Mezey, "Attitudes to Psychiatry in the General Hospital," *British Medical Journal* 4 (Oct 1970): 106-108.
[163] Neill, "Adolf Meyer and American Psychiatry Today", 460.
[164] Franklin G. Ebaugh, "Adolf Meyer, A Tribute from Home," *American Journal of Psychiatry* 123:3 (September 1966): 334.

modern" and his influence in the field was greatly enhanced by the dispersal of his students throughout the country during a period of rapid growth in the profession. Additionally, Ebaugh remarked that Meyer supported the mental health movement, the construction of new hospitals and clinics, as well as "other endeavors which promised to be useful in the melioration of mental illness."[165] Ebaugh was not sure if Meyer was truly an innovator or if he was just a "popularizer of ideas which led to the advancement of psychiatry." Finally, he wrote that this was a puzzle which might never be solved, but what mattered most about Meyer was that "he saw a better way and that he acted on his convictions."[166]

As this chapter has argued however, it appears that puzzle may be solved. It is clear that the ideas which Ebaugh saw as central to Meyer's psychiatric approach were initially derived from his German and Swiss medical school education, as well as his time spent in France and Britain. Shaped by his travels and personal hardships, Meyer learned to adapt his teachings in order to benefit the patients and institutions in which he worked. In time, he became the most influential psychiatrist in North America during the first half of the twentieth century. As Ebaugh and other historians have noted, Meyer's ideas and practices were conveyed to his students, and many went on to assume leadership positions in psychiatry departments, general hospitals, and other health care institutions across American, Britain, Asia, Europe, and Canada.[167] Looking at the dispersal of his students, Meyer trained over 100 psychiatrists who founded their own academic psychiatry departments all throughout the English-speaking world.[168] In this Meyerian diaspora, Nova

[165] Ebaugh, "Adolf Meyer", 336.
[166] Ebaugh, "Adolf Meyer", 336.
[167] Lamb, *Pathologist of the Mind*, 2.
[168] Lamb, *Pathologist of the Mind*, 98.

Scotia saw one of Meyer's disciples establish a psychiatry department at Dalhousie University. Consequently, if the spread and influence of these reform ideas are to be better understood, then an examination of their circulation into Nova Scotia must be conducted. As with many of the settings where Meyer's ideas travelled, this Canadian province provides historians with a case study which demonstrates how his reforms were achieved within a distinctive health care environment as they facilitated psychiatric normalization between 1900 and 1970.

Chapter V

Robert O. Jones and the Influence of Meyerian Ideas in Nova Scotia

With the aim of entirely reforming North American psychiatry, Meyer primarily spread his ideas across the continent's medical community in two ways. The first saw Meyer with his colleagues and students at Johns Hopkins publish articles in the leading psychiatric medical journals such as the *AJP* and the *JAMA*. These effectively communicated his ideas within this wider psychiatric, medical, and intellectual cohort.[1] Secondly, through his department of psychiatry at Johns Hopkins University Medical School, Meyer taught generations of psychiatrists to use the psychobiological perspective when examining and treating patients. He also passed his reform ideas on to each of his psychiatry students, as well as other somatic physicians and specialists more generally.[2]

As Meyer's theories and students migrated, his reforms came into effect across much of the western world including the Canadian province of Nova Scotia which was deeply affected by these Meyerian ideas. Many of the societal, political, cultural, and economic factors which played prominent roles in shaping North American psychiatry also influenced the development of the specialty in Nova Scotia. Within medicine specifically, the same changes which occurred in the somatic fields and psychiatry can all be observed in Nova Scotia over this same period. At the turn of the century, as was seen around much of the continent, psychiatry was an isolated specialty in Nova Scotia. By the 1970s, as those

[1] Adolf Meyer, "The Aims and Meaning of Psychiatric Diagnosis," *American Journal of Psychiatry* 74:2 (October 1917): 163-168; Kempf, "The Behavior Chart In Mental Diseases", 761-772; Ebaugh, "The Crisis in Psychiatric Education, Chairman's Address", 703-707.
[2] Lamb, *Pathologist of the Mind*, 2, 98; Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 357.

external factors shaped society's views on mental illness, and as Meyer's ideas permeated the province, psychiatry slowly became normalized within the medical profession. In this sense, Nova Scotia acts as a case study that reveals the specific avenues through which Meyer's ideas traveled along as they entered into new psychiatric communities and health care settings. Nova Scotian psychiatrist Robert O. Jones studied under Meyer at Johns Hopkins from 1939 to 1941 as a post-graduate in what was one of Meyer's last classes as head of the department. Not only did Jones learn directly from Meyer, but he became a advocate of the wider Meyerian reform strategy. Like Charles Macfie Campbell at Harvard, or any of the other 100 academic psychiatrists who Meyer trained, Jones went on to establish an academic department of psychiatry at Dalhousie University Medical School. As head of the department, Jones became an advocate for Meyerian ideas in the province while he also taught new psychiatrists and specialists the specifics of Meyer's approach to psychiatry and medicine. Through Jones and his work, psychiatry in the province was established as a discipline on par with other specialties.

Beginning in 1941 when Jones returned from Baltimore, he brought with him psychobiology as well as the five other reform ideas, all of which he tried to initiate in the province's hospitals, its mental health care system, the medical school, and society more broadly. At Dalhousie, Jones conveyed to students that psychiatry was a medical science, that mental illness had to be medicalized, and these patients should be treated no differently than the physically ill. But in an effort to create general hospital inpatient units, outpatient services, and community care clinics, Jones had to argue against powerful members of the provincial government and other physicians who did not want the mentally ill to be treated in these hospitals. Finally, Jones also became a leader within the provincial and national

mental hygiene or mental health advocacy movement so as to disseminate Meyerian ideas and to help bring these reforms to fruition. Until his retirement in 1975, Jones worked to ensure that a reformation in psychiatry and mental health care would succeed in Nova Scotia. By exploring the migration which these Meyerian ideas made into the specific health care environment of Nova Scotia, it can be determined exactly how these reforms were understood by physicians the region, and how these ideas ultimately led to the normalization of psychiatry in the province by roughly 1970.

Within much of the foundational historiography on Nova Scotia and its relationships with the rest of Canada and America, the province was often regarded as a distant enclave. During the first half the twentieth century, scholars suggested that the region fell into decline as it became increasingly isolated from the economic, industrial, and political advances which happened in Quebec, Ontario, and in the north eastern U.S. These interpretations have come under much scrutiny in recent decades as historians have shown that while the province struggled financially in comparison to central Canada, it was still an animated hub of commercial activity and cultural growth despite its perceived lack of political power or economic autonomy.[3] When medicine and psychiatry are considered amidst these historiographical trends, their development solidifies the notion that Nova

[3] S. A. Saunders, and Canada, Royal Commission on Dominion-Provincial Relations, "*The Economic History of the Maritime Provinces: A Study Prepared for the Royal Commission on Dominion-Provincial Relations,*" (Ottawa: [s.n.], 1939), 1-148; T. W. Acheson, "The National Policy and the Industrialization of the Maritimes, 1880-1910," *Acadiensis* 1:2 (Spring 1972): 3-28; David Alexander, "Economic Growth in the Atlantic Region, 1880 to 1940," *Acadiensis* 8:1 (Autumn 1978): 47-76; E. R. Forbes, "Consolidating Disparity: The Maritimes and the Industrialization of Canada during the Second World War," *Acadiensis* 15:2 (Spring 1986): 3-27; Margaret Conrad, "The Atlantic Revolution of the 1950s," in *Beyond Anger and Longing: Community and Development in Atlantic Canada*, ed., Berkeley Fleming (Fredericton: Acadiensis Press, 1988), 53-96; Ian McKay, "The Idea of the Folk," in *The Quest of the Folk: Antimodernism and Cultural Selection in Twentieth-Century Nova Scotia*, ed., Ian McKay (Montreal and Kingston: McGill-Queen's University Press, 2014), 3-43.

Scotia was a vibrant and inventive region in Canada in the post-World War II era. The ideas which came to the province, especially after Jones returned in 1941, demonstrate that Nova Scotia was part of an interconnected network of medical and psychiatric innovation which stretched across much of the continent. Through these ideas, the subsequent reforms helped to shape psychiatry, mental health care, and medicine more broadly throughout the region. Although larger metropolitan areas have traditionally been considered as the centers of medical modernity, the history of psychiatric care in Nova Scotia shows that the province was a significant innovator in its own right and that it kept pace with the reforms happening elsewhere in North American at roughly the same time.

As Jones later clarified, many of Meyer's reform ideas had entered into the province by the early 1940s through organizations like the Nova Scotia Society for Mental Hygiene (NSSMH), which emerged in 1920 as the successor to earlier organizations.[4] Yet Jones emphasized that there were few consequential reforms which came to Nova Scotia during this period. As he asserted, "nothing happened" before the 1940s to dramatically alter the province's mental health care services or the practice of psychiatry.[5] Without any governmental support, new clinical facilities were found only at Dalhousie's medical school and they were established using Rockefeller Foundation funding. During the pre-World War II era, Meyerian ideas were circulating into the province, but with new psychiatric services being exclusive to Dalhousie, tangible infrastructural reforms across the province's mental health system and general hospitals were still years away from being initiated.[6]

[4] Fingard, Rutherford, *Protect, Befriend, Respect*, 1, 20.
[5] DUA Jones, MS 13 14, Box 49, Folder 40, (1974), R. O. Jones, *Mental Health in Nova Scotia*, 4.
[6] DUA Jones, Jones, *Mental Health in Nova Scotia*, 3.

One reason for psychiatry's inability to expand into Nova Scotian general hospitals was a lack of well-trained personnel. The editorial board of the *Nova Scotia Medical Bulletin* (*NSMB*) — the leading periodical for the province's medical community — highlighted this issue in 1935. They wrote "the proportion of our graduates who are interested in psychiatry is very small," and suggested that this situation had to be solved immediately.[7] As Jones later outlined, there was always a shortage of physicians at the province's largest asylum, the Nova Scotia Hospital (NSH) with only a superintendent and an assistant to manage the care of roughly 500 patients. For instance by the mid-1920s, these responsibilities fell to superintendent Robert William Murray MacKay and his assistant Pearl Hopgood.[8] Eliza Brison was the only other qualified psychiatrist in Nova Scotia, but she dedicated the majority of her practice to child psychiatry, persons with intellectual disabilities, and occupational therapy.[9] Former superintendent William Harrop Hattie had experience in dealing with mental illness, but he left the NSH in favor of a professorship at Dalhousie in 1914 and only lectured occasionally on these conditions.[10]

There was one new psychiatrist trained during this period, Clyde Slocomb Marshall. Having graduated from Dalhousie in 1923,[11] Marshall worked as a general practitioner for a year and was then offered a Rockefeller fellowship which granted him the opportunity to study psychiatry and neurology. As psychiatrist Patrick Flynn wrote in the Dalhousie Department of Psychiatry's own account of its history, Marshall ventured to the Boston Psychopathic Hospital for psychiatric training in 1925, and then moved to the

[7] Editorial, "Psychiatry in Nova Scotia," *Nova Scotia Medical Bulletin* 15:3 (1935): 144.
[8] "Halifax Medical Society," *Nova Scotia Medical Bulletin* 2:5 (1923): 33.
[9] DUA Jones, Jones, *Mental Health in Nova Scotia*, 4; Fingard, Rutherford, *Protect, Befriend, Respect,* 22.
[10] Patrick Flynn, *Dalhousie's Department of Psychiatry: A Historical Perspective* (Halifax: Department of Psychiatry, Dalhousie University, 1999), 6.
[11] "Dalhousie Medical College," *Nova Scotia Medical Bulletin* 2:5 (1923): 12.

Massachusetts General Hospital for neurology. In 1927 the CNCMH published a report which made recommendations to provinces on how to ameliorate their mental health care systems. This swayed the Nova Scotian government to consider adding a "psychopathic" pavilion and a psychiatry department to the Victoria General Hospital (VGH). Marshall appeared to be the best choice for the director's position but plans for the pavilion and the department fell through while he was in Boston. Not long after their decision, Marshall returned and became the provincial psychiatrist. In this post he assisted in founding the Nova Scotia Training School for the intellectually disabled, established the first psychiatric clinic at the University Health Centre, and lectured at Dalhousie in 1930.[12] Later that year however, Marshall was ultimately steered back to the United States after his contractual obligations with the government were complete.[13] This time, he left for Yale University to complete research on the study of human relationships.[14] Though such a position surely appealed to Marshall because it offered greater professional distinction, Jones suggests that he also left Nova Scotia because the local medical community was "somewhat uncongenial for his progressive ideas."[15] Marshall would not come back until 1941 when he took up a private practice with his brother.[16]

Despite some Nova Scotia physicians acknowledging that the province needed more psychiatrists,[17] a shortage persisted throughout the 1930s. Consequently, general hospital psychiatric services were not developed and wider reforms in psychiatric care could not be

[12] "Locals and Personals," *Nova Scotia Medical Bulletin* 7:4 (1928): 44; Flynn, *Dalhousie's Department of Psychiatry*, 11-12; William Harop Hattie, "Mental Hygiene," *Nova Scotia Medical Bulletin* 9:2 (1930): 79.
[13] Flynn, *Dalhousie's Department of Psychiatry*, 12; Fingard, Rutherford, *Protect, Befriend, Respect*, 28.
[14] "Dalhousie University and C. M. A. Notes," *Nova Scotia Medical Bulletin* 9:8 (1930): 456.
[15] DUA Jones, Jones, *Mental Health in Nova Scotia*, 5.
[16] "Personal Interest Notes," *Nova Scotia Medical Bulletin* 20:7 (1941): 268.
[17] Editorial, "Psychiatry in Nova Scotia", 144.

initiated. To better understand the attitudes other physicians held towards psychiatry at this time, it is necessary to discuss Harold "Benge" Atlee, Professor of Obstetrics and Gynaecology at Dalhousie. During the 1920s and 1930s, Atlee was a Canadian leader within his specialty, and he recognized that a patient's psychological health played an important role during pregnancy and after childbirth. Having come to this conclusion, Atlee sought to convince his colleagues of psychiatry's value.[18] In 1934 he wrote that somatic physicians were still largely ignorant towards mental illness as many did not "realize how widespread social maladjustment is or how its symptoms can mock those of organic disease."[19] For Atlee this was a mistake and he contended that the mentally ill deserved the same level of care which the physically ill received.[20] Regardless of Atlee's stature he found it difficult to convince his peers that Dalhousie had to open its own psychiatry department and that general hospital wards should be made available for the mentally ill. As Flynn argues, this was due to internists and surgeons being indifferent to the idea of "establishing psychiatric beds in their general hospital!"[21] In this respect Nova Scotia and Dalhousie mirrored other regions, hospitals, and medical schools as psychiatry was not initially welcomed into these settings. Atlee remained unfazed and was determined to have his colleagues acknowledge psychiatry's value.[22] Between 1934 and 1937 Atlee was provided with further evidence that Dalhousie had to improve its psychiatric curriculum. Over these years, the AMA's Council on Medical Education and Hospitals appraised sixty-six American and ten Canadian medical schools. The report evaluated each institution so

[18] Wendy Mitchinson, "H. B. Atlee on Obstetrics and Gynaecology: A Singular and Representative Voice in 20th-Century Canadian Medicine," *Acadiensis* 32:2 (Spring 2003): 5-7.
[19] H. B. Atlee, "Psychological Medicine," *Nova Scotia Medical Bulletin* 13:7 (1934): 350.
[20] Atlee, "Psychological Medicine," 350.
[21] Flynn, *Dalhousie's Department of Psychiatry*, 14-15.
[22] Flynn, *Dalhousie's Department of Psychiatry*, 15.

that faculties and administrative officers could learn from the best schools. The Council determined that "Psychiatry has not yet found itself in the medical curriculum," but in citing Ebaugh's research they suggested that his ideas on psychiatry — ideas which came from Meyer — should be emphasized in medical school psychiatry departments.[23]

In 1935, the editorial board of the *NSMB* wrote that the province needed one individual to be trained as an academic psychiatrist so they may establish a school of psychiatry at Dalhousie.[24] With the findings of the Council report Atlee believed it was time to find a student who would become Dalhousie's new psychiatrist. According to Murray and Flynn, in 1937, Atlee thought one of his interns would be the ideal candidate. Once coming to this realization, Atlee stormed into the intern quarters at the VGH, went straight to Robert O. Jones and told him that he should be Dalhousie's "academic psychiatrist." There was only one problem. Jones did not want to be a psychiatrist.[25] Though Atlee was persuasive, Jones told his professor that could not see himself practicing psychiatry. Jones reasoned that with the experience he already had with psychiatry, the field was dull, and he did not want to deal with the chronically insane he observed at the NSH. Having made the decision, Jones opted for a different career path.[26]

Analysis of Jones' life history, however, reveals fascinating details of journey towards medicine. As Jones wrote in a biographical sketch, he was born in Digby, Nova Scotia on March 31, 1914. At that time his father was a railway station agent, but

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[23] Council on Medical Education American Medical Association, Herman G. Weiskotten, Alphonse M. Schwitalla, William D. Cutter, Hamilton H. Anderson, *Medical Education in the United States 1934-1939*, Prepared for the Council On Medical Education and Hospitals of the American Medical Association (Chicago: American Medical Association, 1940), 14, 204-205.
[24] Editorial, "Psychiatry in Nova Scotia", 144.
[25] Murray, *Noble Goals, Dedicated Doctors*, 243-244; Flynn, *Dalhousie's Department of Psychiatry: A Historical Retrospective*, 14-15.
[26] Flynn, *Dalhousie's Department of Psychiatry*, 17.

eventually he worked his way up to become the manager of the Canadian Pacific Railway's hotels in Nova Scotia. According to Jones, his family was "always travelling from point to point and were seldom together in one spot."[27] Despite the travel and his father's frequent absence, his childhood was a happy one, but Jones became interested in medicine out of necessity. At age 10, it was discovered that he had sugar in his urine and physicians thought he was diabetic.[28] With this diagnosis, Jones decided early on that if he had to constantly monitor his own health he should learn as much about the human body as possible. From that point on, Jones wanted to become a physician. When he graduated high school at 16, he enrolled at Dalhousie and received his Bachelor of Science degree in 1933. Jones then went to medical school and in 1937 he obtained his degree.[29]

Having declined Atlee's offer, Jones went to work as a surgeon on the *Arras*, a hospital ship owned and operated by the Canadian government which was deployed in Newfoundland for the summer of 1937.[30] Following his time at sea, Jones travelled to England where he intended to pursue internal medicine. Interestingly, while working at St. Bartholomew's Hospital in London, Jones tested his blood sugar and it was finally determined that his diabetes had been renal glycosuria all along.[31] While abroad, Jones lost interest in internal medicine and applied to a post-graduate program in neurology. Despite his newfound fixation, Jones was not accepted into the program. If Jones were to become a neurologist, he reasoned that some training in psychiatry might be beneficial since the two disciplines were so closely associated. Jones then signed up for a course in "Psychological

[27] DUA Jones, MS 13 14, Box 51, Folder 25, (1939-41), Robert O. Jones papers Supplement 1, Personal Papers, Adolf Meyer at Johns Hopkins, Robert O. Jones, "Biographical Sketch," (October 1, 1939), 1.
[28] DUA Jones, Jones, "Biographical Sketch," 1.
[29] Flynn, *Dalhousie's Department of Psychiatry*, 16.
[30] Flynn, *Dalhousie's Department of Psychiatry*, 18.
[31] DUA Jones, Jones, "Biographical Sketch", 1-2; Flynn, *Dalhousie's Department of Psychiatry*, 16.

Medicine" at the celebrated Maudsley Hospital and became an "extern" under Edward Mapother and Aubrey Lewis. At the same time, Jones observed a lecture series by Bernard Hart, a neurologist at the National Hospital for Nervous Diseases, Queen's Square, London. Jones wrote that these lectures were "like a ray of shining light" which made him realize that "psychiatry did more than describe disease, then fold its hands and let nature take its course."[32] His experiences in England convinced Jones that "psychiatry was an important, all-inclusive field of medicine" that could provide a true understanding of human suffering.[33] At this moment Jones realized that Atlee might have been right. In 1938, he wrote to Atlee and asked if the offer to train in psychiatry was still available? Atlee and the Dean of Medicine, Harry Grant, arranged for the Rockefeller Foundation to supply Jones with a Fellowship to the Phipps Institute of Psychiatry.[34] Even by the late 1930s, it is telling that the Rockefeller Foundation still paid for students to train under Meyer. After setting sail in November of 1938, Jones found a letter from Adolf Meyer waiting for him in Halifax. As Meyer wrote, he expected Jones to be in Baltimore on September 1, 1939.[35]

Little is known about the years Jones spent in Baltimore, yet he kept a series of journal articles written by Meyer, as well as other teaching materials, speeches, and lecture notes which Jones personally marked. Many of these items illustrate that psychobiology was still the centrepiece of the Meyerian approach. They also indicate that students were schooled in the five major reform ideas which shaped North American psychiatry. With regards to psychobiology, Jones preserved a copy of Meyer's 1915 article "Objective

[32] Flynn, *Dalhousie's Department of Psychiatry*, 18.
[33] Flynn, *Dalhousie's Department of Psychiatry*, 18-19.
[34] "Personal Interest Notes," *Nova Scotia Medical Bulletin* 18:7 (1939): 412.
[35] Flynn, *Dalhousie's Department of Psychiatry,* 19-20. See Appendix, Image 4.

Psychology or Psychobiology with Subordination of the Medically Useless Contrast of Mental and Physical."[36] As Meyer wrote and Jones underlined, psychobiology was a refutation of mind-body dualism, mind-brain parallelism, and medical materialism. Meyer then explained that psychobiology focused on the functioning of the total person and not "detachable parts."[37] And integrated into the whole human organism were "simple or complex adaptive and constructive reactions of overt and implicit behavior."[38] Once the health of the entire individual was recognized as a series of psychobiological reactions, then psychiatrists could practice medicine in the same way as their somatic counterparts since they dealt with the objective facts of the patient. For instance, Meyer required students to take meticulous notes during all clinical demonstrations and patient examinations. Case histories were documented beginning with the patient's present illness, their home setting, work environment, and the evolution of their symptoms. Along with somatic evidence gleaned through medical testing, these pieces of information comprised the necessary psychobiological data which allowed psychiatrists to interpret the causes of a patient's mental disorder. From here, diagnosis and prognosis were determined, and the correct treatment approach could be administered. These aspects allowed Meyerian psychiatry to function as an active medical science with genuine therapeutic methods unlike those of Kraepelin or Freud.[39]

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[36] DUA Jones, MS 13 14, Box 51, Folder 25, (1939-41), Robert O. Jones Papers Supplement 1, Personal Papers, Adolf Meyer at Johns Hopkins, Adolf Meyer, "Objective Psychology or Psychobiology with Subordination of the Medically Useless Contrast of Mental and Physical," *Journal of the American Medical Association* (4 September 1015): 1.
[37] DUA Jones, Meyer, "Objective Psychology or Psychobiology with Subordination of the Medically Useless Contrast of Mental and Physical," 4.
[38] DUA Jones, Meyer, "Objective Psychology or Psychobiology with Subordination of the Medically Useless Contrast of Mental and Physical," 4.
[39] DUA Jones, MS 13 14, Box 51, Folder 25, (1939-41), Robert O. Jones Papers Supplement 1, Personal Papers, Adolf Meyer at Johns Hopkins, Adolf Meyer, *Psychobiology (Ergasiology),* (n.d.): 1, 5, 6, 8, 9,

Having been taught that psychiatry and psychobiology were a part of medical science, Jones was then educated on Meyer's other reform ideas. Meyer communicated that mental illness should be medicalized so that the care which the mentally ill received was comparable to that of the physically ill. This was due to Meyer's belief that both mind and body were involved in the development of mental disorders as well as physical conditions. As Meyer wrote "All that constitutes psychobiology to the physician is, therefore, physical as well as mental."[40] Psychiatrists and somatic physicians therefore had to be knowledgeable on all aspects of human health if all patients were to receive proper treatment. The next logical step forward in the Meyerian approach was to dismantle the institutional and professional partitions which separated psychiatry from somatic medicine. To achieve this goal Meyer asserted that psychiatrists had to "win the attention of the medical profession" by showing that their expertise was useful to their colleagues.[41] For psychiatrists to prove their value to other physicians then they had to enter general hospitals and medical schools.[42] Mental hygiene was another topic in his curriculum with Jones having kept a paper on this subject. In the article, Meyer wrote that the mental hygiene movement should promote the study of mental illness in society. Additionally, the advocacy movement was meant to spread awareness on mental health while also encouraging an interest in the subject within "existing departments in mental health in schools and at large."[43] With Jones having read this Meyerian material, he recognized that

[40] DUA Jones, Meyer, "Objective Psychology or Psychobiology", 2.
[41] DUA Jones, Meyer, "How Can Our State Hospitals Promote A Practical Interest In Psychiatry Among The Practitioners?", 3.
[42] DUA Jones, Meyer, "How Can Our State Hospitals Promote A Practical Interest In Psychiatry Among The Practitioners?", 7; Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 332.
[43] DUA Jones, MS 13 14, Box 51, Folder 25, (1939-41), Robert O. Jones Papers Supplement 1, Personal Papers, Adolf Meyer, "The Birth and Development of the Mental-Hygiene Movement," *Mental Hygiene* 19:1 (January 1935): 2-3.

the key to ending psychiatry's isolation was to "gain the attention of the rational practitioner."[44] This was still a pernicious problem in Nova Scotia as physicians such as Hattie, Atlee and others had trouble convincing the provincial medical community of psychiatry's merits. As Meyer had taught, Jones recognized that psychiatry had to be brought into general hospitals and medical students required more comprehensive schooling in the specialty. More broadly if the wider reform strategy could be put into place then psychiatric normalization would be forthcoming.

Having fulfilled his duties as "House Officer" on the Psychiatric Service at Johns Hopkins Hospital, Jones received his signed certification from Meyer on September 1, 1941 and returned to Halifax.[45] As Flynn explains, Jones soon "set up the beginnings of a department" with financial assistance from the Rockefeller Foundation amounting to $2,500 a year for teaching and clinical work. The funding was renewed again after 1944 and carried on well into the 1950s.[46] With this support, Jones dedicated his time towards developing the department and a curriculum, as well as the Dalhousie psychiatric clinic which he took charge of in 1942.[47] Simultaneously, Jones formed relationships with Samuel Prince, president of the NSSMH and MacKay at the NSH. According to Fingard and Rutherford, Jones understood that mental health care in the province would be greatly enriched if a "cadre of mental health professionals" worked together.[48] Yet outside of psychiatry and mental hygiene, Murray explains that Jones was met early on with

[44] DUA Jones, Meyer, "How Can Our State Hospitals Promote A Practical Interest In Psychiatry Among The Practitioners?", 9, 4.
[45] DUA Jones, MS 13 14, PB Box 1, Folder 105, Adolf Meyer at Johns Hopkins, "This Certifies that Dr. Robert O. Jones has served as HOUSE OFFICER on the Psychiatry Service of The Johns Hopkins Hospital during the twenty-four months ending (September 1st, 1941)." See Appendix, Image 5.
[46] Flynn, *Dalhousie's Department of Psychiatry*, 21.
[47] R. O. Jones, "The Positive Diagnosis of Neurosis," *Nova Scotia Medical Bulletin* 21:5 (1942): 144.
[48] Fingard, Rutherford, *Protect, Befriend, Respect*, 41.

"obstructions and resistance."[49] In one instance, a senior surgeon said "Poor Bob Jones, he's going to starve here. There's no need for psychiatrists in Halifax."[50] To convince his peers of psychiatry's worth and to transform Nova Scotia's mental health care system, Jones set out to initiate the broader Meyerian reform strategy.

In November 1941, Jones presented the new psychiatry through an article in the *NSMB* titled "Psychiatric Contributions to the General Practice of Medicine." As Jones explained, present day psychiatry "treats the individual person" and believes that "human difficulties may arise from various factors."[51] For general practitioners, Jones wrote, modern psychiatry was useful as their expertise delivered important insights into "any sort of medical case," and because these physicians often saw mentally ill patients, so they had to know how to manage them correctly.[52] Jones then described that multiple factors such as organic disorders, and physiologic or endocrine changes, could cause mental illness. Yet the root of the problem may also lie in the individual's personality as they were affected by changes in their living situation, work related stress, marital troubles, past failures, or their worries for the future. According to Jones, psychiatrists were to be well-rounded physicians, knowledgeable on the illnesses of the body while general practitioners had to be more aware of the patient's problems of personality. He also affirmed that psychiatry was now a fundamental of general practice that stood along with anatomy, physiology, pathology, and therapy. All physicians had to grasp the notion that "one deals with a closely knit together organism" that could not be separated into "distinct entities of body

[49] Murray, *Noble Goals, Dedicated Doctors*, 258.
[50] Murray, *Noble Goals, Dedicated Doctors*, 258.
[51] R. O. Jones, "Psychiatric Contributions to the General Practice of Medicine," *Nova Scotia Medical Bulletin* 20:11 (1941): 361.
[52] Jones, "Psychiatric Contributions to the General Practice of Medicine," 361.

and mind, nor yet into individual organs."[53] Each patient was an individual and "must be treated as such."[54] In this article, Jones provided an overview of Meyer's psychobiology which refuted the division of mind and body. Psychiatry was now positioned as one of the foundational components of modern medicine, and Jones also introduced the idea that mental illness is as common as any physical illness. Consequently, these patients must be treated in a more medicalized manner.

Having informed the province's medical community on the basics of Meyerian psychobiology, the next task for Jones was to educate medical students. As Flynn writes, the new professor wanted to overhaul the existing psychiatric curriculum by focusing more on a "co-ordinated and relevant program of lectures and case presentations occupying all four years of medical school."[55] The intention here was to teach students that psychiatry was an objective science and to convince them that psychiatry observed the "functioning of the person as a whole."[56] This permitted the specialty to "develop as a branch of medicine" which recognized that some physical illnesses may be psychological in origin (psychosomatic), while some mental illnesses may be somatic in origin (somatopsychic).[57] Through this approach, psychiatry at Dalhousie would integrate into the medical school. As for his teachings, a document titled "Outline of First Year Course," clarified that students would learn of "objective psychobiology." This provided a complete theoretical and practical foundation of the "functioning of a live person," and it consisted of studies on the "personality-functions of normal individuals" which benefitted all medical students. The

[53] Jones, "Psychiatric Contributions to the General Practice of Medicine", 362.
[54] Jones, "Psychiatric Contributions to the General Practice of Medicine", 362.
[55] Flynn, *Dalhousie's Department of Psychiatry*, 23.
[56] Flynn, *Dalhousie's Department of Psychiatry*, 23.
[57] Flynn, *Dalhousie's Department of Psychiatry*, 23.

rationale being that physicians of every sort had to understand "the range of variation in the functioning of the rank and file of normal individuals, and the factors playing a role in the problems of health, happiness and efficiency."[58] Second year students moved on to study common conditions such as anxiety, depression and schizophrenia. Third years were given instruction mostly in clinical psychiatry using real cases which Jones had dealt with in his private practice and the clinic. Fourth year students visited chronic patients at the NSH and other county facilities. They also gained experience in taking patient histories and performed mental state exams.[59] Of utmost importance for students was learning that psychiatrists had to decipher the illness of a patient both pathologically and psychopathologically, where mental disorders were understood and treated as they formed in the psyche. Treatment was then based on their diagnosis of the patient and these features made the new psychiatry a medical science that was comparable to all other specialties.[60]

Crucially, Jones made it clear that his entire program at Dalhousie was centered around Meyer's theory of psychobiology. In a 1957 lecture titled "Psychiatry and Education," Jones informed students of the intellectual lineage of which they were a part. As he explained, "this presentation arose from the need to speak to our new Residents on the psychiatric philosophy which we adhere to in this teaching centre."[61] The working philosophy at the heart of the psychiatry department as well as in "most other teaching centres on this continent springs directly from the formulations of the late Dr. Adolf

[58] DUA Jones, MS 13 14, Box 51, Folder 25, (1939-41), Robert O. Jones Papers Supplement 1, Personal Papers, Adolf Meyer at Johns Hopkins Meyer, "Outline of First Year Course", (n.d.): 1.
[59] Flynn, *Dalhousie's Department of Psychiatry*, 24-26, 21-22.
[60] DUA Jones, Meyer, *Psychobiology (Ergasiology)*, 3.
[61] DUA Jones, Jones, MS 13 14, Box 47, Folder 19, Victoria General – Residents - Teaching Materials - Psychiatry and Education (Adolf Meyer) (n.d.), Robert O. Jones, *Psychiatry And Education*, (1957): 4.

Meyer."[62] By passing these ideas to students, Jones was implementing Meyer's vision at Dalhousie. Not only were his theories at the foundation of their curriculum, but psychobiology was meant to guide all practitioners of medicine as it taught them to observe patients as whole human organisms and that each patient should be viewed as a unique individual. Having developed a curriculum in psychiatry, Jones quickly fulfilled two of Meyer's major reforms. First, he ameliorated psychiatric education, and secondly psychiatry was being recognized as a proper medical science at least in medical school and amongst students. To complete the wider Meyerian reform strategy however, and to achieve the normalization of psychiatry in Nova Scotia, Jones had to reach the rest of the profession.

Though Jones had informed his colleagues in 1941 of the new psychiatry, it was unreasonable to think the province's medical community would abruptly accept psychiatric ideas into their own practices or general hospitals. In May 1944 Jones attended the centennial meeting of the APA, and reported in the *NSMB* that his field was moving away from "specialized hospitals" as psychiatry aimed to take a more active role in the community and general medicine by creating liaisons with other medical departments in general hospitals.[63] This article came at an opportune time as the province was planning major renovations to the VGH, but absent from their designs were a psychiatric inpatient unit or an outpatient clinic. On July 4, 1944, the Executive of the Medical Society of Nova Scotia (MSNS) held their annual meeting and the topic of a psychiatric unit in the VGH became a major discussion point that evening. The Western Nova Scotia Medical Society

[62] DUA Jones, Jones, *Psychiatry And Education*, 4.
[63] Robert O. Jones, "The Centennial Meeting of the American Psychiatric Association," *Nova Scotia Medical Bulletin* 23:7 (1944): 166-167.

from Yarmouth asked to pass a resolution on establishing such a unit because these physicians had patients in need psychiatric treatment, but they believed commitment to a mental institution was too stigmatizing. The Minister of Health, Frank Roy Davis, himself a former surgeon, expressed that the government had considered this issue, but they felt a psychiatric ward with even 50 beds would do little to fix the province's problems with mental illness. Halifax physician Kenneth MacKenzie then uttered his opinion and "pointed out the embarrassment of having psychiatric patients in a general medical ward."[64] Evidently there were physicians in Nova Scotia who opposed the idea of the mentally ill being in general hospitals. At this moment, Jones asserted that a general hospital psychiatric unit was not meant to solve mental illness in Nova Scotia. Its purpose was to "take care of the psychiatric cases which develop within the hospital and which also are admitted to the hospital as medical or surgical cases."[65] It seems these comments were disregarded as Davis concluded this portion of the meeting by affirming that there were still no plans for a psychiatric unit at the VGH.[66]

Years later Jones reminisced about his sparring sessions with the province's ministers of health on general hospital psychiatry and the resistance he often faced from somatic physicians. According to Jones, early in the 1940s he asked the government for assistance in adding psychiatric services to general hospitals, but the minister at the time "loudly proclaimed he was not going to have crazy people in his hospitals."[67] If Davis served as Minister from 1933 until his untimely death in 1948, then the unnamed minister

[64] "Minutes of the Executive of the Medical Society of Nova Scotia, 1944," *Nova Scotia Medical Bulletin* 23:8 (1944): 223.
[65] "Minutes of the Executive of the Medical Society of Nova Scotia, 1944," 223.
[66] "Minutes of the Executive of the Medical Society of Nova Scotia, 1944," 222-223.
[67] DUA Jones, *Community Mental Health Medical Services Insurance In Nova Scotia*, 4.

must be Davis.[68] With the available evidence it is difficult to know for certain if Davis made such an inflammatory remark or if he truly opposed psychiatry in the way Jones described. Yet with the MSNS meeting, the comments from MacKenzie, and the later quote from Jones, there is much corroborative evidence to suggest that psychiatry was not embraced by all physicians in the province. The debate at the MSNS meeting also indicates that physicians completely misunderstood the purpose of a general hospital psychiatric unit. Of course, such a small unit could not solve mental illness in the province, but it would provide the proper environment within which to treat cases that develop in hospitals. Meanwhile Jones knew full well that such a ward would bring psychiatry closer together with somatic physicians for the benefit of both branches of medicine.

While Jones waited to gain space within the VGH, he continued his work at the Dalhousie clinic. Between 1944 and 1946 Jones wrote annual reports which help to illustrate the challenges he encountered as a practicing psychiatrist. In 1945, Jones described that the clinic accepted 837 new patients, including public, semi-private, and private cases for examination and treatment. According to Jones, the clinic's intake policy was meant to limit all cases which required "long periods of treatment."[69] Instead, Jones made every effort to treat patients swiftly in the early stages of a disorder, and all within the limitations of "outpatient and general hospital facilities."[70] This is another example of Meyerian ideas being used in this clinical setting. Furthermore, by concentrating on acute cases in a community clinic, Jones was instituting another of Meyer's approaches in his

[68] H. A. Fraser, "In Memoriam, Frank Roy Davis, M.D., C.M. (Dal), F.A.C.S.," *Nova Scotia Medical Bulletin* 27:10 (1948): 236-238.
[69] DUA Jones, MS 13 14, Box 45, Folder 6, (1941-1942), R. O. Jones, "Report of Psychiatric Clinic," 1.
[70] DUA Jones, Jones, "Report of Psychiatric Clinic," 1.

own practice. In this sense Jones was showing his superiors that clinics were places where people with an acute disorder could seek fast and effective treatments such as "narco-analysis, modified insulin, and electro convulsive therapy," as well as short-term Meyerian "commonsense" psychotherapy.[71] In following Meyer's reform strategy, Jones also suggested that patients who required longer term inpatient therapy would have to be treated as inpatients in general hospital psychiatric units.

Regardless of the success which Jones was having at the clinic, he confessed the "case load is still far more than can be adequately handled without staff facilities."[72] To improve the quality of care and to aid in the normalization of psychiatry, Jones made suggestions that would help fulfill these goals. With regard to psychiatry's integration into the medical school, Jones noted that the teaching load has "increased yearly" and the clinic had become a vital asset as students in all four years were taught through the clinic. Significantly, Jones explained that the teaching of psychiatry had grown in popularity and requests had been made to double the amount of psychiatric instruction given to students.[73] With the clinic being so near the university Jones could get students more engaged with patients, and this added to their interest in the field, as Meyer said would occur once psychiatric clinics became a part of university medical schools. Most notably, Jones described how somatic physicians were becoming more interested in psychiatry and some were acknowledging its utility. For instance, Jones wrote that "contact with the medical profession of the province seems to be getting closer all the time and more and more people

[71] DUA Jones, Jones, "Report of Psychiatric Clinic", 1; Flynn, *Dalhousie's Department of Psychiatry*, 31.
[72] DUA Jones, Jones, "Report of Psychiatric Clinic", 1.
[73] DUA Jones, Jones, "Report of Psychiatric Clinic", 1-3.

are asking for information and help with psychiatric problems."[74] Evidence of this shift was apparent as physicians across the province were accepting psychiatric materials for most medical meetings, and many practitioners requested further training in psychiatry at Dalhousie refresher courses.[75]

According to Jones however, progress was being thwarted because the province lacked training opportunities for physicians to specialize in psychiatry. Fortunately, the university planned to add a post-graduate program that would resolve this issue. With money from the Federal Health Grants, Dalhousie had enough funding to establish a fully functioning Department of Psychiatry. Jones became Professor of Psychiatry and Head of Department, while Frank A. Dunsworth, a psychiatrist trained in Toronto and at the prestigious Menninger Clinic in Topeka, Kansas was appointed as Assistant Professor.[76] According to Flynn, with these grants, Dalhousie "no longer had to rely on" the Rockefeller Foundation, and the department took on its first three residents in July 1949.[77] Now with their own independent department, psychiatry had been effectively integrated into the medical school. But to truly improve the quality of care for the mentally ill as well as psychiatry's standing as a specialty, Jones argued that the province had to develop facilities where physicians could be exposed to psychiatric patients and where they could be trained in how to treat these cases. As he claimed, "the staff of the Hospital has repeatedly gone on record as asking for such a thing and certainly public opinion is very much behind the establishment of psychiatric facilities in our general hospitals."[78] Although no unit was

[74] DUA Jones, Jones, "Report of Psychiatric Clinic", 3.
[75] DUA Jones, Jones, "Report of Psychiatric Clinic", 3.
[76] "Expansion of Psychiatric Teaching," *Nova Scotia Medica Bulletin* 28:3 (1949): 91; Flynn, *Dalhousie's Department of Psychiatry*, 38-44; Murray, *Noble Goals, Dedicated Doctors*, 239.
[77] Flynn, *Dalhousie's Department of Psychiatry*, 44.
[78] DUA Jones, Jones, "Report of Psychiatric Clinic", 5-6.

being constructed at the VGH, Jones felt there were great possibilities for facilities to be developed there with this sort of support for psychiatry.

With the hospital staff behind him, Jones started treating patients in the VGH, though none were officially admitted as psychiatric patients. Jones clarified that the hospital's Board of Commissioners were reluctant to take in these patients and they were adamant that all psychiatric cases should be sent to the NSH though the facility was overcrowded. Gradually Jones began to notice that the number of psychiatric patients grew and even without a full ward the psychiatrists working at the VGH "were operating a rather large psychiatric service on the general wards."[79] These physicians cared for patients who had "previously been problems to the hospital" and many of these cases were useful clinical material for medical students.[80] Regardless of these achievements, some physicians remained intolerant towards psychiatry and the mentally ill. In one example, Jones wanted to admit a severely depressed and suicidal patient to the VGH for long term treatment and asked the administrators if this would be allowed. According to Jones, this resulted in "something near to a panic" in the superintendent. Jones then had to appear before the full staff to get their support and gave a presentation which was meant to persuade them that depression was a genuine illness deserving of hospital care. Partway through his lecture, one of the hospital's "most distinguished surgeons" belittled Jones and asked if he had examined the patient's mouth for bad teeth. Despite the surgeon's hostility, Jones was able to convince the staff to allow the patient into the hospital. In his recounting of this incident Jones stated that this surgeon soon became an ally to psychiatry. Just five years after their

[79] Flynn, *Dalhousie's Department of Psychiatry*, 30.
[80] Flynn, *Dalhousie's Department of Psychiatry*, 30.

quarrel, the surgeon demanded from the Minister of Health that a psychiatric unit be established in the VGH and that any new hospital without such a unit "was as silly as building a hospital without an operating room."[81]

Evidently Jones had proven to this surgeon and other physicians by the 1950s that psychiatry had value. As Jones wrote to Dalhousie President A. E. Kerr on February 8, 1951, "the majority of teaching at all levels goes on at the Victoria General Hospital and this is widely used for the medical students of all years, for the training of post-graduate students and other personnel." Jones then outlined that the Camp Hill Veterans Hospital had entered into an arrangement whereby the university's department "became responsible for Psychiatry at this institution."[82] At Camp Hill they were given a 30-bed unit where psychiatrists demonstrated to students, nurses, and social workers "the workings of a well-rounded psychiatric program."[83] Slowly it can be observed that, in Nova Scotia, Jones was succeeding in carrying out many of Meyer's reform ideas. Psychiatry had gained a small foothold in the city's main general hospital as well as a full unit in the veterans' hospital, both of which were used to teach medical students and to treat patients. Evidently psychiatry was becoming more normalized within somatic medicine in the province. Yet as the stories of other physicians and their negative attitudes illustrate, there was still much professional hostility being directed towards psychiatry. To fully achieve integration, Jones once again relied on Meyer's teachings. In this context, Jones continued to educate his

[81] DUA Jones, MS 13 14, Box 50, Folder 13, The Place of Psychiatry in a General Hospital (for Speech at Saint Joseph's Hospital, Milwaukee - Annual Clinic Day (1964), R. O. Jones, "The Place of Psychiatry in a General Hospital," 7-8; Flynn, *Dalhousie's Department of Psychiatry*, 31.
[82] DUA Jones, MS 13 14, Box 34, Folder 2, Robert O. Jones, Paper Supplement 1, Professional Activities, Nova Scotia, Health Services Insurance Commission, Psychiatric Advisory Committee, (1971-75), Robert O. Jones, "Letter to Doctor A. E. Kerr, 14 January 1950," 3.
[83] DUA Jones, Jones, "Letter to Doctor A. E. Kerr, 14 January 1950," 3.

peers with refresher courses featuring guest lecturers from George S. Stevenson of the APA, Wendell Muncie from Johns Hopkins, and Cornell's Alexander Leighton.[84]

Additional Meyerian ideas took hold in Nova Scotia through the mental hygiene movement which by the late 1940s was becoming the mental health movement as the term evoked a more positive and inclusive meaning for all consumers of mental health services.[85] At the annual APA meeting in 1948, Jones delivered a speech titled "Psychiatric Opportunities in a Small Community." In the address Jones explained that psychiatrists congregated in large urban centers and this left many towns and cities with populations of 50,000 to 100,000 without a practicing psychiatrist.[86] Jones wrote of his experiences practicing in Halifax, and suggested that if the specialty were to have a greater impact on modern health care and society, it was critical for psychiatrists to become more closely connected with somatic physicians and the people of these smaller communities. To attain these goals Jones recommended that psychiatrists take every opportunity to speak to interested groups on mental hygiene, to cooperate with any group or agency in planning and implementing community projects, to identify closely with the rest of the medical profession by attending meetings and joining organization.[87] Furthermore, in smaller communities Jones asserted that psychiatrists were a "powerful force" in that they helped to "to shape community enterprises, such as education, law practices and so on, in a direction of better mental hygiene."[88] The role Jones suggested that psychiatrists adopt is precisely the part he played in Halifax, and evidence of this can be seen in his work with the

[84] DUA Jones, Jones, "Letter to Doctor A. E. Kerr, 14 January 1950," 2.
[85] José M. Bertolote, "The roots of the concept of mental health," *World Psychiatry* 7:2 (June 2008): 113-116.
[86] Robert O. Jones, "Psychiatric Opportunities in a Small Community," *American Journal of Psychiatry* 106:1 (July 1949): 69.
[87] Jones, "Psychiatric Opportunities in a Small Community", 69.
[88] Jones, "Psychiatric Opportunities in a Small Community", 72.

province's mental health advocacy movement during the 1940s and 1950s, especially as Meyerian reforms soon came to fruition.

As Meyer had preached for decades, the key to psychiatry's integration was to be found through education and outreach. When Jones returned to Halifax, he got involved in the local mental hygiene movement and became a member of the NSSMH's executive committee, and then served as vice president in 1946. During these years, Jones "contributed immensely to public education about mental health as a public speaker at meetings of service clubs, professional organizations, home and school organizations, and his own medical society."[89] Jones also introduced the province to "treatment modalities" such as electroconvulsive therapy.[90] The Society's own historical calendar illustrates that Jones helped to accomplish a number of previously unachievable goals. The psychiatric clinic which had been "long advocated by the Society" was finally opened in 1941.[91] Then, in 1945, the Society conducted a survey of Nova Scotian physicians asking if a psychiatric unit should be opened at the general public hospital. With a majority approving of the idea, the Society put forward a resolution to the Minister of Health to establish a unit and in 1948 the VGH opened its psychiatric ward.[92]

In 1951, the NSSMH received a charter from the newly named Canadian Mental Health Association (CMHA), and the Society decided to become a division of the national organization, though they would keep their original name for five more years. A year later,

[89] Fingard, Rutherford, *Protect, Befriend, Respect*, 41.
[90] Fingard, Rutherford, *Protect, Befriend, Respect*, 41.
[91] DUA Jones, MS 13 14, Box 78, Folder 1, Canadian Mental Health Association, Nova Scotia Division, Nova Scotia Society for Mental Hygiene - Executive A) Meetings and Correspondence (1952-1959), "The Nova Scotia Society for Mental Hygiene: Canada's Pioneer Society for Mental Health, A Calendar of a Generation of Advance," *Nova Scotia Society for Mental Hygiene*, (n.d.), 2
[92] DUA Jones, Canadian Mental Health Association, Nova Scotia Division, "The Nova Scotia Society for Mental Hygiene," 2.

Samuel Prince retired as president and Jones took the position until 1955. Through his involvement, Jones was able to expand his own influence in the province, and Meyerian ideas became the core of the NSSMH's reform agenda. For instance, one of his key recommendations was for mental health services to be further regionalized with community care clinics being established throughout the province. Jones also called for stronger links between the province's mental hospitals and general hospitals, as well as its mental hygiene clinics and mental health services.[93] Jones believed that laypeople should lead the society, and he transferred power to new president Eric Balcom in 1956. But the society's constitution written that same year bears the marks of Meyer's reform strategy: the study, investigation and dissemination of information on the cause and prevention of mental illness and mental defectiveness, and the promotion of mental health; "the training, care and general welfare of mentally defective persons and persons mentally diseased"; and, most significantly, "the development of hospitals, institutes, clinics, training schools, auxiliary classes, care committees, psychiatric service and other means of promoting mental hygiene."[94] As this evidence demonstrates, Jones influenced the shape, direction, and aims of the local advocacy movement as he led the province towards the adoption of additional Meyerian reforms such as the opening of a psychiatric unit in the VGH and closer cooperation between psychiatrists and somatic physicians.

[93] DUA Jones, MS-13-14, Box 78, Folder 1, Canadian Mental Health Association, Nova Scotia Division. Nova Scotia Society for Mental Hygiene - Executive A) Meetings and Correspondence (1952-1959), Robert O. Jones, "Presidential Report, Canadian Mental Health Association," (13 February 1953), 4, 5, 6; Fingard, Rutherford, *Protect, Befriend, Respect*, 47-48, 50.
[94] DUA Jones, MS-13-14, Box 78, Folder 1, Canadian Mental Health Association, Nova Scotia Division. Nova Scotia Society for Mental Hygiene - Executive A) Meetings and Correspondence (1952-1959), Nova Scotia Society for Mental Hygiene, "Proposed Constitution of N.S. Society for Mental Hygiene," (17 February 1956), 1.

One of the most significant Meyerian ideas which Jones supported in Nova Scotia was the community care clinic. Psychiatric clinics had been proposed by the NSSMH years earlier, but with Jones having learned of their importance from Meyer, he quickly became a proponent of them in his professional career. In 1952, Jones read a paper before the CMA titled "The Place of the Psychiatrist in the Community Medical Services." As he explained, one of the most considerable changes in medicine since the 1920s was the "rapid emergence of the psychiatrists from within the walls of the mental hospital to engage in practice in the community."[95] Jones estimated that in North America there were approximately 7,900 practicing psychiatrists and 3,900 now spent at least part of their time in private practice while "many others serve in community out-patient clinics, child guidance clinics, etc."[96] Jones suggested that the reason for this shift was due to the realization amongst many psychiatrists that effective therapy for the mentally ill could be conducted in community clinics. Consequently "the patient is spared the necessity of commitment to a mental hospital."[97] This is of course a fundamentally Meyerian idea. Community clinics allowed for people to have their mental disorder treated closer to home by a psychiatrist and an interdisciplinary team of mental health care workers while their disorder was still in its acute stages. By the 1950s, Jones underscored the importance of community clinics in a modern mental health care system. With attention being brought to these new pieces of mental health care infrastructure, other figures in the province's government and health care apparatus began to consider the possibility of opening clinics

[95] Robert O. Jones, "The Place of the Psychiatrist in the Community Medical Services," *The Canadian Medical Association Journal* 68:1 (January 1953): 1.
[96] Jones, "The Place of the Psychiatrist in the Community Medical Services", 2.
[97] Jones, "The Place of the Psychiatrist in the Community Medical Services", 2.

around the province as they were a more proactive alternative to the custodial county homes.

In her historical assessment of Nova Scotia's Community Mental Health Movement, author Joanna Redden states that in 1948 the provincial government's Department of Public Health founded the Division of Neuropsychiatry, and Clyde Marshall became its director.[98] One of his top priorities was to create a system of community mental health centres. Yet there was still a limited number of properly trained psychiatrists and mental health care professionals employed in the province. To cultivate a larger workforce Jones helped to establish Dalhousie training programs for social workers, psychologists, and nurses. With these training programs, students learned the skills necessary to allow them to work with psychiatric patients, and they could be deployed across the province in rural hospitals and clinics. As these new mental health care workers slowly streamed out of their training programs, the province was finally in a position to build and staff these clinics "with a psychiatrist, a psychologist, and a social worker."[99] Beginning in 1949, the first of these institutions was founded in Yarmouth, followed by the Digby Clinic in 1951, the Halifax Mental Health Clinic For Children in 1954, and the Fundy Mental Health Centre, as well as the Western Region Mental Health Clinic in 1955.[100] The following year Marshall wrote in his *Report of the Inspector of Human Institutions* that the "psychiatric needs of the community are taken care of, in part, by the development of a number of

[98] Clyde Marshall, "Work of the Neuropsychiatric Division of the Department of Public Health," *Nova Scotia Medical Bulletin* 27:6 (1948): 141; Fingard, Rutherford, *Protect, Befriend, Respect*, 41-42.
[99] Joanna Redden, *The Community Mental Health Movement in Nova Scotia, 1945-69: The Case of the Fundy Mental Health Centre* (MA Thesis, Dalhousie University, 2000), 6, 55.
[100] Redden, *The Community Mental Health Movement in Nova Scotia*, 66, 77, 72.

psychiatric clinics."[101] These clinics were "cooperatively organized" and the communities themselves participated "in a great many ways."[102] With these community clinics stationed throughout rural Nova Scotia, people living well outside of Halifax now had much closer access to psychiatric treatment.

Within this network of community mental health centres, the Digby Clinic was an outlier in that it was not a direct product of the provincial government. This particular clinic came about as a result of Leighton's Stirling County Study, but rather than being an exception to the government's overall plan, both the clinic and study were heavily influenced by Meyerian ideas. As for the origin of the study itself, its beginnings were rooted in the friendship between Leighton and Jones. Remarkably, the two psychiatrists befriended one another when they were children. Jones lived in Digby, and Leighton's family visited the town each summer. Twenty years later, the pair wound up studying together in Baltimore at the same time.[103] Having learned their craft from Meyer, Leighton and Jones were enthusiastic advocates for community care. The Stirling County Study itself was built upon "Meyerian concepts and methods, to survey the distribution of mental illness in the general population."[104] When Leighton sent a report to the provincial Department of Health, he wrote that clinics were a useful tool in the fight to prevent mental illness as they "rehabilitated some who would otherwise be patients in a mental hospital."[105] As for the Digby Clinic, Redden explains that it was a triumph which proved

[101] Clyde Marshall, "Report of the Inspector of Humane Institutions," Nova Scotia, Inspector of Humane Institution, *Humane Institutions [annual Report]* (1956), 33.
[102] Marshall, "Report of the Inspector of Humane Institutions," 33.
[103] Fingard, Rutherford, "Social Disintegration, Problem Pregnancies, Civilian Disasters", 197.
[104] Lamb, *Pathologist of the Mind,* 255.
[105] PANS RG 25 Vol. 690, No. 6, Alexander Leighton, "Research Design in the Stirling County Study, A Research Program in the Social Factors Related to Psychiatric Health," Report submitted to the Department of

to mental health administrators that clinics could play a vital role in the community and encouraged the construction of additional community mental health centres.[106]

The development of community clinics gained the attention of most physicians throughout Nova Scotia. For example, in 1953 at the executive meeting of the MSNS, it was reported that a new psychiatric clinic in Sydney "has been operating at full capacity."[107] The clinics were also recognized as a truly positive innovation in Canadian mental health care. A confidential report printed by the Scientific Planning Committee of the Canadian Mental Health Association's Nova Scotia Division from 1956 examined the proliferation of these clinics and wrote that "their method of organization and operation has evoked considerable interest throughout the country."[108] Evidently there was truth to this statement. In 1962, Marshall published an article in *Mental Hospitals* entitled "Treatment Close to Home: The Nova Scotia Mental Health Plan." In the article, Marshall outlined that mental health clinics were to be in close proximity to where patients lived, and care was medicalized which encouraged patients to seek these services. Hospital inpatient care had to be available if necessary while general practitioners and private psychiatrists "should be made part of the program." Continuity of care had to be ensured so that all physicians and mental health care workers gave patients the correct treatment throughout the duration of their disorder. Psychiatrists and physicians were to communicate with one another, and in

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Health and Welfare in support of a request for a Dominion Provincial Mental Health Grant, 8; as cited in Redden, *The Community Mental Health Movement in Nova Scotia*, 70.

[106] Redden, *The Community Mental Health Movement in Nova Scotia*, 70.

[107] "Minutes of the Executive of the Medical Society of Nova Scotia," *Nova Scotia Medical Bulletin* 33:1 (1954): 23.

[108] DUA Jones, MS 13 14, Box 78, Folder 1, Canadian Mental Health Association, Nova Scotia Division. Nova Scotia Society for Mental Hygiene - Executive A) Meetings and Correspondence (1952-1959), Scientific Planning Committee, "Report of the Sub-Committee on Mental Health Services in the Community," *Canadian Mental Health Association, Nova Scotia Division (Proposals for Mental Health Services in the Province of Nova Scotia)*, 2.

doing so, psychiatrists became "a real functioning part of the local medical community."[109] When assessing the development of Nova Scotia's community mental health centres, it can be observed that they are a regional extension of the ideas which were first introduced in North America by Meyer. Furthermore, these facilities brought psychiatry closer to the somatic specialties by requiring that psychiatrists, general practitioners, and other specialists were all incorporated into patient care. In this way community care aided in the process of psychiatric normalization.

Because of his commitment to reform, the ideas which Jones introduced to Nova Scotia started to flourish during the 1950s as psychiatry continued to integrate with somatic medicine. Progress often came first through his department at Dalhousie. As Jones described to Kerr in 1951, "the activities of the Department of Psychiatry of Dalhousie University have greatly expanded."[110] This was due in part to the funding first provided by the Rockefeller Foundation, and later through government grants, as well as cooperation from the Nova Scotian Department of Health. Jones also suggested that the people of the province played a significant role in popularizing psychiatry as many were acknowledging the importance of mental health. Furthermore, Jones explained that psychiatry benefitted from the new teaching opportunities at the VGH and other hospitals.[111] Jones then reported that his department added five new staff members, psychiatrists Kenneth Hall, R. J. Weil, Liba and James Tyhurst, and social worker Andrew Crook. With the extra personnel the department could teach more students as many were finally showing an interest in

[109] Clyde Marshall, "Treatment Close to Home: The Nova Scotia Mental Health Plan," *Mental Hospitals* 13 (June 1962): 306, 313.
[110] DUA Jones, MS 13 14, Box 34, Folder 2, Robert O. Jones, Paper Supplement 1, Professional Activities, Nova Scotia, Health Services Insurance Commission, Psychiatric Advisory Committee, (1971-75), Robert O. Jones, "Letter to Doctor A. E. Kerr, 8 February 1951," 1.
[111] DUA Jones, Jones, "Letter to Doctor A. E. Kerr, 8 February 1951," 1.

psychiatry. According to Jones, evidence of this was seen in the number of students who wanted to "pursue psychiatric studies as post-graduates" and by the positive comments which students made on their experiences with the department. As for post-graduates, seven residents were being trained and another four had already applied for the following year. Practicing physicians were also paying greater attention to psychiatry as the faculty often spoke at medical society lectures across the Maritime Provinces and across Canada. With the Dalhousie program having been approved for Royal College certification, the College also acknowledged that Jones's department was "part of their University integration."[112] By 1959 Jones tabulated that 40 psychiatrists had completed his post-graduate program, and 25 were now "working full-time in public service facilities in Atlantic Canada with another half-dozen associated part-time while also teaching or practising privately."[113] These details suggest that psychiatry was making great strides towards normalization in the decade since Jones arrived at Dalhousie.

In order for complete psychiatric integration to occur however, the specialty still had to acquire more physical space and professional freedom within general hospitals. With psychiatrists working at the VGH and Camp Hill, this process was already well underway in Nova Scotia, although there was much room for growth. For instance, Jones recognized that psychiatrists at the VGH needed greater autonomy, and this required that they come out from under the departmental control of neurology. As Marshall explained in 1948, neurology and psychiatry were combined into the Neuropsychiatric Division so that other physicians could see how psychiatry was "related to neurology and that it is an integral part

[112] DUA Jones, Jones, "Letter to Doctor A. E. Kerr, 8 February 1951", 2-8.
[113] Flynn, *Dalhousie's Department of Psychiatry*, 86.

of medicine."[114] Though this arrangement was beneficial for a time, Jones found that it had become a hindrance. In a letter written on December 8, 1951 to C. M. Bethune, superintendent of the VGH, Jones requested a reorganization of the department. He argued that with Marshall as the head of neurology, he held authority over psychiatry and "all administrative matters" went through him. This meant that if Jones wanted to make a request of the administration Marshall had to approve of it first. More importantly, Jones reasoned, there were always significant decisions being made by the hospital administrators and department heads which affected the psychiatrists and their patients, but psychiatry had no say in these matters. For Jones, it made more sense to have the department split into its constituent parts so that psychiatrists could make decisions based on their own best interests and those of their patients. To conclude, Jones wrote "we are most anxious to go on working with Neurology and Neuro-Surgery but we do not feel that we should work for them."[115] While they may have needed neurology years earlier, Jones felt confident that psychiatry should be an individual department at the VGH and it was deserving of the same privileges as neurology, obstetrics, or any other field.

Though the separation did not happen immediately, this transition can be observed in the hospital's annual reports. For instance in 1952, Marshall was noted as the head of neuropsychiatry, while Jones was the psychiatrist on staff along with Dunsworth, Weil, Hall, and J. F. Nicholson who were assistants.[116] Two years later, the department was divided into Neurology, Psychiatry, and Neuro-Surgery, but the hierarchy remained the

[114] Marshall, "Work of the Neuropsychiatric Division of the Department of Public Health", 141.
[115] DUA Jones, MS 13 14, Box 34, Folder 2, Robert O. Jones, Paper Supplement 1, Professional Activities, Nova Scotia, Health Services Insurance Commission, Psychiatric Advisory Committee, (1971-75), R. O. Jones, "Letter to C. M. Bethune, Re: Department of Neurology, Psychiatry and Neuro-Surgery, Victoria General Hospital," (8 December, 1951), 1-3.
[116] C. M. Bethune, *Eighty-Fifth Annual Report*, Victoria General Hospital, Appendix 4, (1952), 6.

same.[117] An independent department was then established in 1955 with Jones as its head. A 24-bed psychiatric unit opened on the second floor of "what was once the Private Pavilion," and outpatient services were created on the main floor.[118] Moreover, during these years the expansion of psychiatric services occurred. In 1952, though psychiatry was still without its own inpatient ward, a total of 1,534 patients were treated by psychiatrists, while 4,265 treatments or visits were registered. The department with the next highest totals were general surgery with 691 patients and general medicine with 3,881 treatments or visits.[119] By 1958, the psychiatry department saw 324 new outpatients while 3,156 returned for more treatment. These figures must be compared again to other departments. Surgical and medical patients were the only two categories with more new patients that year with 764 being seen for surgery and 486 for medical. But with returning patients, the totals for psychiatry far surpassed those in the medical category at 2,137. These figures are significant because they illustrate that far from overwhelming hospitals as some physicians feared, psychiatric outpatients were not a tremendous burden. Although many patients returned for treatment, this was a positive sign that the clinics were operating as Meyer had intended. If patients could have their disorder assessed quickly by a psychiatrist in the inviting confines of a modern general hospital, then patients were encouraged to return for treatment and their condition would not become chronic. As for the inpatient ward, psychiatrists treated 154 patients that year, far fewer than surgical patients which totalled 2,784. Another important figure is that the average number of days spent on the ward by psychiatry patients was 19. This compares favorably to other departments in that the

[117] C. M. Bethune, *Eighty-Seventh Annual Report*, Victoria General Hospital, Appendix No. 34, (1954), 8.
[118] Flynn, *Dalhousie's Department of Psychiatry*, 69; Bethune, *Eighty-Seventh Annual Report*, 11.
[119] Bethune, *Eighty-Fifth Annual Report*, 23.

average for dermatology was 17 days, while the vaguely titled department "Medical C" had a high of 26.[120] These records demonstrate that inpatients did not stay in the hospital for weeks, months, or years. Once patients could have their disorders dealt with by a psychiatrist in a general hospital then even severe cases were likely to seek treatment long before their illness became incurable.

Having achieved departmental autonomy at the VGH and Camp Hill, psychiatry in the 1960s spread out into other hospitals. As Dunsworth wrote in 1963, psychiatric services were now entering into the Halifax Infirmary. In quoting *More For The Mind*, the CMHA's landmark study on psychiatric services, Dunsworth reminded readers that mental illness should be dealt with in the same "organizational, administrative and professional framework as physical illness."[121] According to Dunsworth, the new unit would enable psychiatrists to comprehensively evaluate patients in their acute stages of disorder in an "open" general hospital service. A treatment team would then organize and apply the necessary "therapeutic orientation" for patients. Psychiatrists were also meant to interact with other hospital departments and services as continuity of care and therapeutic services were to be maintained.[122] With psychiatric units now dispersing into new general hospitals in Nova Scotia, it is apparent that Meyerian ideas were still at the core of psychiatry's development in the 1960s. And with their proliferation into other hospitals, clearly administrators and physicians were warming to psychiatry as the field continued to normalize within the province's medical community.

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[120] Bethune, *Ninety-Second Annual Report*, 14, 6.
[121] F. A. Dunsworth, "The Psychiatric Service at the Halifax Infirmary," *Nova Scotia Medical Bulletin* 42:11 (1963): 370.
[122] Dunsworth, "The Psychiatric Service at the Halifax Infirmary," 370.

Now well into his second decade as a practicing psychiatrist, Jones still travelled to medical and psychiatric conferences. In 1964, he was invited to St. Joseph's Hospital in Milwaukee, Wisconsin for their "Annual Clinic Day." His speech, "The Place of Psychiatry in a General Hospital," gave Jones the opportunity to reflect on his career and the struggles he had in developing a psychiatric department at the VGH. Jones also framed the success of general hospital psychiatry in Nova Scotia around Meyerian ideas. For instance, a large "psychiatric service" in the hospital was useful in the teaching of all medical students. The unit also "proved useful to the people of Nova Scotia" as it "aided the care of many patients who previously had been problems to the hospital."[123] While somatic physicians had long opposed welcoming the mentally ill into general hospitals, Jones argued that "the forces that were on the move throughout the medical world at this time" greatly inspired the founding of his psychiatric ward. Jones mentioned the war, the federal government's health grants, and national hospital insurance which all influenced general hospital psychiatry in Canada. Crucially, Jones quoted from the 1964 Royal Commission on Health Services which explained that the divisions between mind and body in medicine, or physical and mental illness were to be "disavowed for all time as unworthy and unscientific."[124] Jones insisted that in Canada, physicians were acknowledging that psychiatric patients should "receive treatment under exactly the same conditions that any other sick person in the community does."[125] Throughout this speech Jones illustrated that the Canadian and Nova Scotian medical communities were opening up to psychiatry. With Jones emphasizing that the distinction between mental and physical was harmful he once again demonstrated how

[123] DUA Jones, Jones, "The Place of Psychiatry in a General Hospital", 6-8,
[124] DUA Jones, Jones, "The Place of Psychiatry in a General Hospital", 11-12.
[125] DUA Jones, Jones, "The Place of Psychiatry in a General Hospital", 11.

Meyer's ideas were shaping psychiatry in the 1960s as normalization was becoming a reality.

Meanwhile inpatient wards, outpatient services, and community clinics were replacing asylums as the norm in Canadian psychiatric care. With Nova Scotia as just one provincial example, Fingard and Rutherford have calculated that from 1955 to 1982 the total population of patients in Nova Scotia's mental institutions fell from 2,551 to 504.[126] Throughout this era general hospital psychiatric services continued to proliferate across the country. In 1963 this point was illustrated at the Fourteenth Meeting of the Advisory Committee on Mental Health when it was reported that before 1940 there were only three units in the entire country, by 1960 that number rose to 45. Inpatient beds also increased between 1951 and 1961 from 225 to 1,348. According to the Dominion Bureau of Statistics, the number of personnel had also risen dramatically by 1961. In the 27 hospitals who reported, there were 158 psychiatrists, 61 residents and interns, 178 psychiatric nurses, 49 psychologists, and 31 social workers.[127] These totals indicate that within Canadian general hospitals, psychiatric wards flourished after the 1940s. Over the same period psychiatrists gained space within general hospitals as the specialty became a normalized part of mainstream medicine.

In the ensuing years as psychiatric units and community clinics continued to expand across Nova Scotia, and as a steady stream of psychiatrists flowed out from Dalhousie, Jones remained a fervent advocate for the Meyerian approach to psychiatry. On September

[126] Fingard, Rutherford, "Deinstitutionalization and Vocational Rehabilitation", 389.
[127] DUA Jones, MS 13 14, Box 78, Folder 6, 1962, Robert O. Jones, Associations, Canadian Psychiatric Association, Executive Meetings and Correspondence, Department of National Health and Welfare, "Minutes of the 14th Meeting Advisory Committee on Mental Health," (May 2 and 3, 1963), 2, 41-48.

29, 1966, at the Eighteenth Mental Hospital Institute in Boston Massachusetts, Jones presented a paper "Appraising the Total Network of Services." In his speech, Jones told his audience that the "total network" was a multi-faceted combination of mental health services which included general hospital psychiatric inpatient units, outpatient clinics, and community mental health clinics. Each of these services were founded upon "a generally accepted set of principles: early and comprehensive treatment readily available and close to patients' homes: minimal hospitalization or none at all; a wide spectrum of community services; and continuity of medical care."[128] Though not explicitly stated, each of these principles were founded upon Meyer's reform ideas, and all helped to bring psychiatry closer to somatic medicine in the United States, Canada, and Nova Scotia by the 1970s. Other psychiatrists within Jones's own sphere of influence had also come to realize how far their field had progressed. As Dunsworth wrote in 1980, psychiatry had been embraced after World War II by the medical schools, psychiatric units in general hospitals "blossomed," and psychiatrists themselves became actively involved in all aspects of medicine. Finally, at long last, "Psychiatry had rejoined the main stream of Medicine — the psyche had been reunited with the soma!"[129]

After a long and distinguished career, Jones retired in 1975. As Murray writes, Jones had "built a modern department, transformed education and trained a new generation of psychiatrists."[130] Over the course of his 34 years in practice, Jones managed to become

[128] DUA Jones, MS 13 14, Box 48, Folder 11, DUA Jones, MS 13 14, Box 48, Folder 11, Appraising the Total Network of Services, For American Psychiatric Association - Mental Hospital Institute -1966 and Hospital and Community Psychiatry (1967), Robert O. Jones, "Appraising the Total Network of Services," *Hospital and Community Psychiatry* (January 1967), 18.
[129] F. A. Dunsworth, "An Outline of Psychiatric Care in Nova Scotia," *Nova Scotia Medical Bulletin* 59:2 (1980): 65.
[130] Murray, *Noble Goals, Dedicated Doctors*, 260.

one of the country's most well-respected psychiatrists. In 1964 Jones was elected President of the CMA. He received the Canadian Centennial Medal in 1967, as well as the Queen's Jubilee Medal in 1977, and was installed as an Officer of the Order of Canada in 1981.[131] After suffering from a short illness, Jones passed away on August 26, 1984 at the VGH. According to his *NSMB* obituarists R. M. MacDonald and Benjamin Doane — his successor as head of psychiatry at Dalhousie — Jones "will always be associated with the development and practice of Psychiatry in Canada, and especially in Nova Scotia."[132]

During his career Jones remained an avowed Meyerian and a prominent one at that. In 1966, Jones was invited by APA to attend the Adolf Meyer Lecture, a speech given annually in honour of the late professor. On the list of participants were familiar characters such as Lidz, Kempf, Leighton, Diethelm, Ebaugh, and Stevenson. Other celebrated psychiatrists Curt Richter and Paul Lemkau of Johns Hopkins, Stanley Cobb of the Massachusetts General Hospital, and Phyllis Greenacre from the New York Psychoanalytic Institute were also meant to attend. Listed right alongside these figures was Robert O. Jones.[133] Jones was an influential physician in his own right as he worked to improve psychiatry and mental health care in Nova Scotia. But, as this thesis has argued, the principles which Jones brought to the province descended from Adolf Meyer. First, he used those reform ideas to transform psychiatric education at Dalhousie. He then taught students and other physicians that the division between mind and body in medicine was flawed, and that through psychobiology psychiatry had to be connected with orthodox medicine. Jones

[131] "Personal Interest Notes," *Nova Scotia Medical Bulletin* 43:7 (1964): 232.
[132] R. M. MacDonald and B. K. Doane, "An Appreciation, Dr. Robert O. Jones," *Nova Scotia Medical Bulletin* 63:4 (August/October 1984): 132-133.
[133] DUA Jones, MS 13 14, Box 51, Folder 25, (1939-41), Robert O. Jones Papers Supplement 1, Personal Papers, Adolf Meyer at Johns Hopkins, Louis Jolyon, "Letter of Invitation," *American Psychiatric Association* (1966), 1-2; Lidz, "Special Section, Adolf Meyer, 1866-1950", 321.

also used mental hygiene and mental health advocacy to spread Meyerian ideas throughout the province. In conveying to other physicians that psychiatry was a medical science, Jones persuaded his colleagues that care for the mentally ill had to be medicalized and treated in the same way as any physical condition. This required psychiatric services to be added to general hospital and for community clinics to be established across the province. Over time opposition to psychiatry was vanquished in the province as Jones instituted Meyer's reform strategy and by the 1970s the specialty normalized within somatic medicine.

Chapter VI

Conclusion

Between roughly 1900 and 1970, psychiatry in North America experienced a remarkable transformation. At the beginning of the century psychiatry was an isolated medical specialty most commonly practiced in mental asylums, while other physicians considered it to be a second-rate discipline. Towards the end of this period, departments of psychiatry opened in medical schools across the continent, general hospitals added psychiatric services, the mental health movement gave psychiatrists a more influential role in society, and the new theories at the heart of the field turned psychiatry into a modern medical science which was commensurate with other specialties. Consequently, psychiatry became an integrated part of the mainstream medical community as normalization was achieved.

Though the subjects of mental health and psychiatry have both received great scholarly attention in the historiography, only a few authors such as Walkup and Abraham had previously assessed psychiatry's route into general hospitals and university medical schools.[1] Yet even within these well detailed studies, limited attention was given to the intellectual basis of psychiatric normalization as well as the ideas which led to the specialty's reformation during the twentieth century. In using an intellectual history methodology, this thesis built upon current accounts of psychiatry's evolution in a way that revealed both the role which prominent psychiatrists played in the normalization of their

[1] Walkup, "The Psychiatric Unit Comes to the General Hospital", 11-23; Abraham, "Psychiatry in American Medical Education", 63-93.

field, as well as the external factors that most shaped this transformation. Through the analysis provided here, new layers of insight were added to this narrative which illustrates how the production and circulation of ideas in the field led to innovations within psychiatry, medicine, and patient treatment. By examining the intellectual foundations of twentieth-century psychiatry in the United States and Canada, it was revealed that the ideas which prompted the specialty's normalization sprang from Adolf Meyer.

Though his theories provided psychiatry with much needed legitimacy, much of Meyer's success was tied to the conditions which existed in psychiatry in 1893. Since the birth of the asylum, superintendents wanted patients to arrive early in the course of their illness. Despite the pleas of these physicians, families were hesitant to send a loved one to a mental institution.[2] In certain instances, patients improved on their own, but with other cases this only led to further mental deterioration and many became incurable. At this point, the mentally ill might financially drain a family, and some were even a violent presence in the household. Under these circumstances, patients were finally institutionalized, and gradually incurable cases amassed in asylums. In this setting moral treatment no longer functioned as originally intended. By the 1890s patient populations grew so large that these physicians adopted bureaucratic and custodial roles and practiced little in the way of medicine.[3] As other specialties in medicine flourished, asylum medicine languished as the most professionally isolated and scientifically deficient of all disciplines.

This was the setting which Meyer entered in 1893. Having trained in Switzerland through the German medical school model, and then learning from French and English

[2] Moran, *Committed to the State Asylum*, 78-79, 97.
[3] Reaume, *Remembrance of Patients Past*, 86; Warsh, *Moments of Unreason*, 125-127; Grob, *From Asylum to Community*, 6; Dowbiggin, *Keeping America Sane*, 235.

physicians, Meyer was an amalgam of his European influences. Having journeyed to America, Meyer brought with him a perspective and approach to psychiatric medicine which was sorely lacking in asylums at that time. Beginning with his first position in Kankakee, Illinois, Meyer adapted his medical knowledge and scientific ideas with those of American psychologists and pragmatist philosophers. Once his ideas were put into action they changed the functioning of the institution and the practices of the physicians on staff.[4] Over time Meyer's talents for reform were observed by more senior psychiatrists, and soon he was recognized as a leader in the field.[5] In 1908 when he was hired by Johns Hopkins University Medical School to be their chief of psychiatry, Meyer turned into the most influential psychiatrist on the continent.[6] With his appointment, the university signalled to the rest of the medical community that psychiatry was to become a more integrated specialty, and Meyer's methods would be the archetype.[7]

Over the length of his career Meyer argued that psychiatry had to end its professional isolation from somatic medicine. But as he observed, the prevailing theoretical understandings of mind-body dualism, mind-brain parallelism, and medical materialism required that afflictions of the mind and body be treated separately in asylums and general hospitals. Each theory had long dominated both psychiatric and somatic medicine, but according to Meyer, they were preventing his field from functioning as a clinical science and they inhibited the assimilation of the specialty into orthodox medicine. To reintegrate psychiatry, Meyer dismantled the divisions between the psychiatric and the somatic with

[4] Lamb, *Pathologist of the Mind*, 4-5, 215.
[5] Lamb, *Pathologist of the Mind*, 45.
[6] Lamb, *Pathologist of the Mind*, 1-3; Scull, *Psychiatry and its Discontents*, 95
[7] Stahnisch, Verhoef, "The Flexner Report of 1910 and Its Impact of Complementary and Alternative Medicine and Psychiatry in North America in the 20th Century", 1, 2, 5.

his theory of psychobiology. The theory itself specified that the mind and body were indivisible aspects of the whole human organism. Through psychobiology, the health of the individual was based on the premise that the body's anatomical and physiological nervous apparatus worked in conjunction with its mental activities and behaviours, and all were part of the human organism's adaptive response to stimuli in the environment. With this interpretation Meyer argued that the divisions between mind and body were pointless and that they had to be replaced with his psychobiological view.[8]

As this theory was the guiding principle of his approach, Meyer then bridged the gap between the psyche and the soma in medicine through five major reform ideas, the first of which was to demonstrate that psychiatry was a medical science by showing that the specialty was open to collaboration with other specialties and professions. Meyer combined clinical, laboratory, and autopsy work with a clinical and pathological approach.[9] In this way Meyerian psychiatrists learned how to study and treat mental disorders. Secondly, care for the mentally ill was medicalized so as to make patients feel that their disorder was a normal medical problem. This led to Meyer's third reform, that general hospitals had to open psychiatric inpatient units, outpatient services, and community care clinics so as to better accommodate these patients.[10] Not only did these facilities allow for psychiatrists to treat patients rapidly, but they also brought psychiatrists physically and professionally closer to other specialists. Meyer's fourth reform was to improve psychiatric education at

[8] DUA Jones, Meyer, "Objective Psychology or Psychobiology with Subordination of the Medically Useless Contrast of Mental and Physical", 1-4; Lamb, *Pathologist of the Mind*, 21.
[9] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 49-50; Meyer, "A Few Trends in Modern Psychiatry", 222; Lamb, *Pathologist of the Mind*, 49, 254.
[10] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 343, 347, 348, 357; Lamb, *Pathologist of the Mind*, 101-102, 112.

medical schools.[11] With psychiatrists walking the same halls as other physicians in general hospitals and teaching students in medical schools, the entire medical community gained more experience with psychiatry, and they were shown that the specialty had value for all practitioners. Over the period in question, this integration of psychiatry, general hospitals, and medical schools was so successful that psychiatry became one of the pillars of physician education alongside anatomy, physiology, pathology, and therapy.[12] The final part of Meyer's reform strategy involved mental hygiene.[13] For the new network of services to work effectively, then mental health advocacy was intended to educate the public on mental illness so that the symptoms of acute disorder could be identified soon after their onset and patients were encouraged to seek treatment early. Significantly, through Meyer's vision, the specialty was no longer consigned to asylums. They were responsible for the mental health needs of society, and their political, medical, and social influence in North America was amplified.[14] When viewed collectively, each of these ideas from psychobiology to mental hygiene were distinctly Meyerian, and as students such as Jones acknowledged in 1973 Meyer "did more than anyone to reduce the gulf which separated psychiatry from general medicine."[15]

During his career from 1893 to 1941, Meyer circulated these theoretical and reform ideas in the leading journals and through his students. Before his retirement in Meyer had trained close to 100 new academic psychiatrists who went on to occupy prominent

[11] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 360-361.
[12] Jones, "Psychiatric Contributions to the General Practice of Medicine", 362.
[13] Meyer, *The Commonsense Psychiatry of Dr. Adolf Meyer*, 312.
[14] Pressman, *Last Resort*, 27; Dowbiggin, *Keeping America Sane*, 11.
[15] DUA Jones, MS 13 14, Box 51, Folder 25, (1939-41), Robert O. Jones Paper Supplement 1, Personal Papers, Adolf Meyer at Johns Hopkins, Robert O. Jones, *The Meaning of Adolf Meyer* (1973), 1-5.

positions all across North America.[16] This meant that at the heart of new medical schools, general hospital wards, and community clinics were Meyerian principles. Through an analysis of articles published in a variety of medical journals it was determined that many of Meyer's central reform ideas were communicated, debated, and initiated in new health care and university settings all across North America. Psychiatrists such as G. V. Hamilton, Edward J. Kempf, and Albert M. Barrett all adopted or interacted with Meyer's psychiatric theories. Over time other prominent psychiatrists and medical associations supported the spread of Meyer's reform ideas. For example, APA presidents Bond, Mitchell, and Eyman all discussed the benefits of psychiatric clinics as they created vital links between psychiatry and other specialties, and that they allowed for greater medical school teaching opportunities. By the 1930s it was clear to many in medicine including the AMA that the road ahead was to be paved with the Meyerian ideas which sought to bring psychiatry into general hospitals and medical schools. By the 1960s and 1970s, these reforms reconnected psychiatry and somatic medicine to the point where authors such as Lebensohn felt comfortable writing that psychiatry was now "going steady" with the rest of medicine.[17] Proof of this blossoming relationship was found in the growing number of American and Canadian medical schools that began to include psychiatry in their curricula. A subject which was barely taught at the turn of the century was incorporated into a majority of medical schools by the 1950s and the curricular prototype was Meyerian psychiatry.[18] Further evidence of psychiatry's integration with orthodox medicine was clear by the 1960s

[16] Lamb, *Pathologist of the Mind*, 98.
[17] Lebensohn, "American Psychiatry and the General Hospital", 47.
[18] Bennett, et al., "Psychiatric Treatment in General Hospitals", 1022; Abraham, "Psychiatry in American Medical Education", 77.

when over 800 psychiatric inpatient units could be found in general hospitals across the U.S., and in Canada the number of psychiatric units increased to 45.[19] As a result of the many reform ideas which Meyer introduced, his specialty was no longer deemed to be outside of the medical mainstream.[20]

As a means to prove the argument that Meyer was the physician most responsible for psychiatry's reformation between 1900 and 1970, Nova Scotia was used as a case study which demonstrated how his ideas influenced the growth of the specialty in one specific region. With this in-depth analysis, it was discerned that without their own Meyerian psychiatrist, reforms in the province's mental health care system and university psychiatry program advanced at a sluggish pace.[21] With the return of Robert O. Jones from Johns Hopkins in 1941, Meyer's ideas poured into Nova Scotia as he initiated the wider Meyerian reform strategy. At Dalhousie Medical School, Jones quickly formulated a curriculum and post-graduate program for psychiatry.[22] With each class, Jones grounded his teachings in psychobiology and ensured that students recognized they were being taught the Meyerian approach to psychiatry and medicine.[23] This allowed Jones to promote other Meyerian ideas such as psychiatry being a medical science, and the medicalization of mental illness.[24] Jones also became a central figure in the province's mental health movement.[25] While he conveyed these ideas to students and the public, Jones endeavoured to introduce psychiatry

[19] Lebensohn, "American Psychiatry and the General Hospital", 48; DUA Jones, Department of National Health and Welfare, "Minutes of the 14th Meeting Advisory Committee on Mental Health", 41-48.
[20] Kellett, Mezey, "Attitudes to Psychiatry in the General Hospital", 106-108.
[21] DUA Jones, Jones, *Mental Health in Nova Scotia*, 4.
[22] Flynn, *Dalhousie's Department of Psychiatry*, 21.
[23] DUA Jones, Jones, *Psychiatry And Education*, 4.
[24] DUA Jones, Meyer, *Psychobiology (Ergasiology),* 3; Jones, "Psychiatric Contributions to the General Practice of Medicine", 362.
[25] Fingard, Rutherford, *Protect, Befriend, Respect*, 41.

into general hospitals in Nova Scotia. Before he could achieve this Jones had to overcome opposition from physicians who still felt psychiatry and the mentally ill had no place in these institutions.[26] Through his efforts to educate colleagues, Jones turned professional opinion in favor of psychiatry.[27] Gradually after 1950, inpatient units and outpatient services were offered in hospitals around the province just as physicians across Canada began to accept that the divisions between physical and mental illness had to be discarded.[28] Jones can then be considered as a model which shows how Meyer's ideas were passed on to students. Essentially Jones served as a component of Meyer's reform strategy as he led the way towards psychiatry's normalization within mainstream medicine in Atlantic Canada.

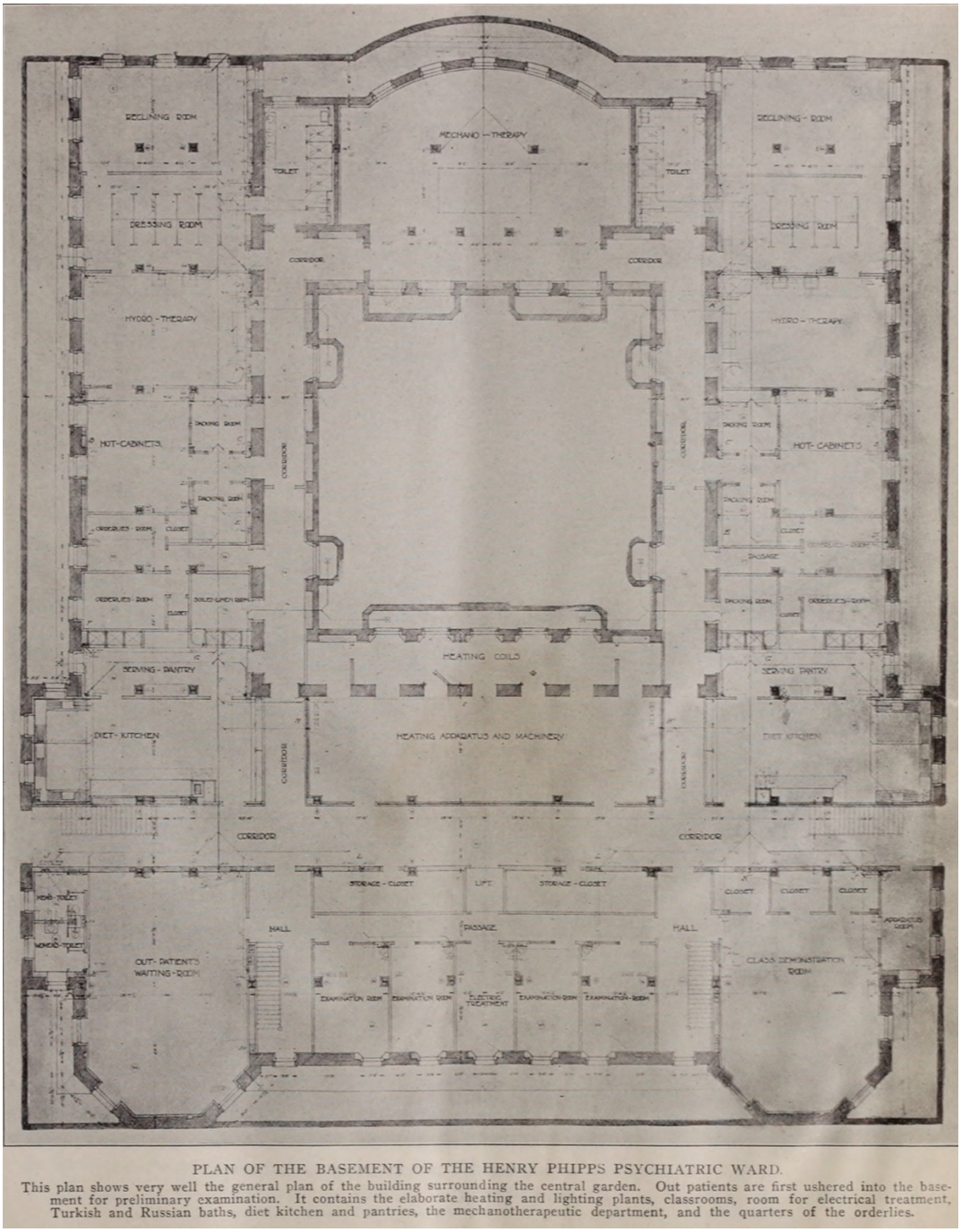
When viewed from an intellectual history perspective, each of the ideas which Meyer developed over the length of his career helped to overturn the previous paradigms in medicine which favored mind-body dualism and mind-brain parallelism. Through his reformulations of the mind and body as indivisible aspects of the whole human organism, psychiatrists were able to end their professional isolation from other medical specialties. With Meyer's theories acting as the foundation for academic and practicing psychiatry, these specialists took on a larger role in society and in medicine during the period examined here. With the spread of Meyerian ideas came the further transformation of psychiatry as his reforms continued to remodel the specialty and the mental health care systems of each new setting, they were applied in. Then as Meyer's ideas and reforms came to dominate the

[26] "Minutes of the Executive of the Medical Society of Nova Scotia, 1944", 222-223.
[27] "Dalhousie Notes," 452.
[28] DUA Jones, Jones, "Letter to Doctor A. E. Kerr, 8 February 1951", 2-8; Bethune, *Ninety-Second Annual Report*, 3, 14, 6; DUA Jones, Jones, "The Place of Psychiatry in a General Hospital", 11-12.

field, psychiatry could boast that it had developed into a biological and medical science. Like never before psychiatrists argued that they had effective therapeutics for patients, that they should be included in general hospitals and medical schools, and that they played a vital role in the management of society. As Meyer's ideas proliferated around the North American psychiatric and medical community, they proved to be so persuasive that the formerly second-rate specialty became fully integrated into somatic medicine. By 1970 it was clear that as a result of Meyer's work psychiatry had normalized within the medical mainstream.

Appendix

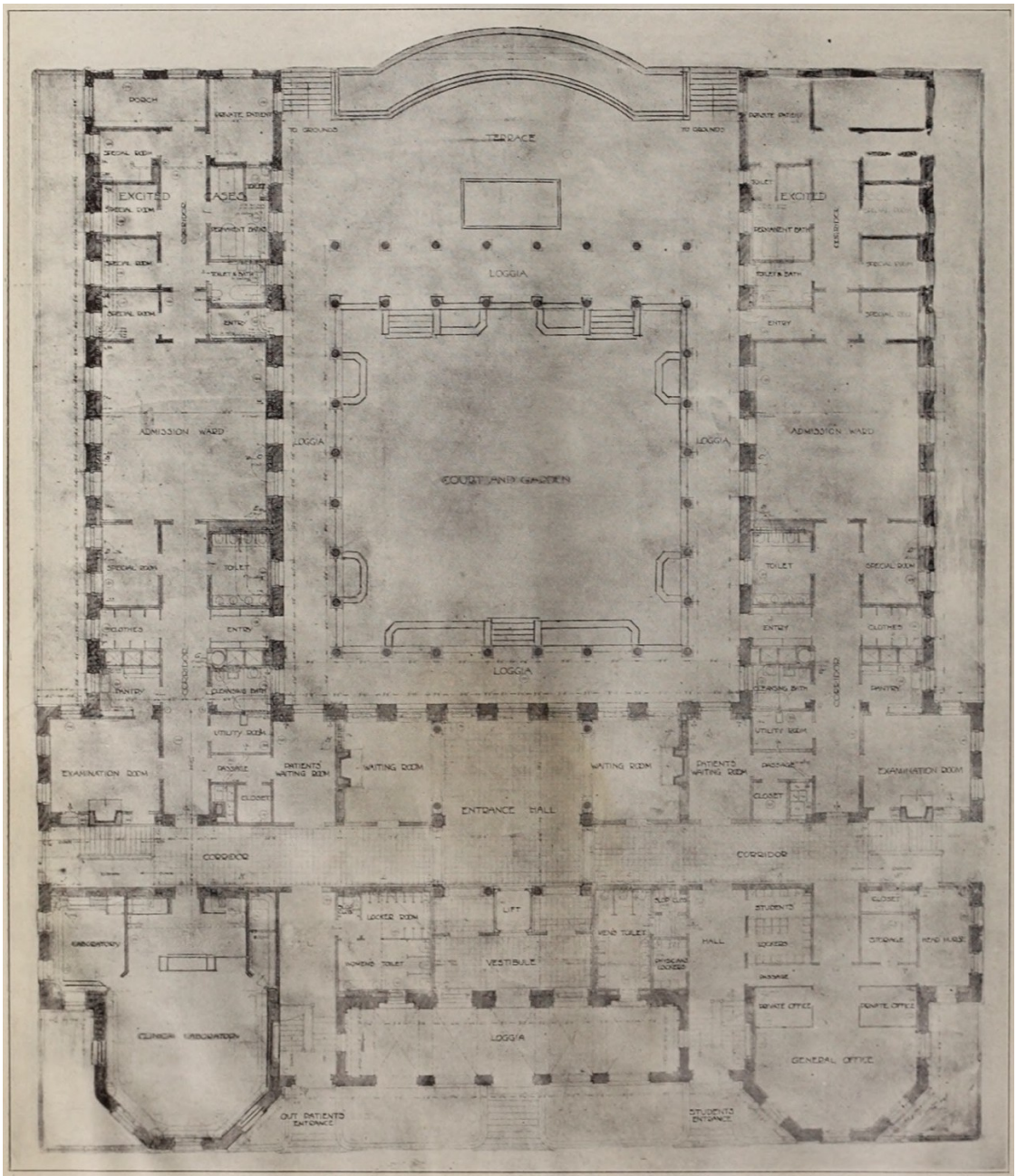
Image 1: An early photo of Adolf Meyer. (Courtesy of the National Library of Medicine. accessed online 10 November 2020. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-101423347-img).



PLAN OF THE BASEMENT OF THE HENRY PHIPPS PSYCHIATRIC WARD.

This plan shows very well the general plan of the building surrounding the central garden. Out patients are first ushered into the basement for preliminary examination. It contains the elaborate heating and lighting plants, classrooms, room for electrical treatment, Turkish and Russian baths, diet kitchen and pantries, the mechanotherapeutic department, and the quarters of the orderlies.

Image 2: The architectural floor plan for the basement of the Henry Phipps Clinic. Of particular significance here is the outpatient waiting room on the bottom left hand corner, and the class examination room on the opposite side. "The Henry Phipps Psychiatric Ward at Johns Hopkins," *New York Medical Journal* (11 September 1909): 513 (Courtesy of the HathiTrust. Accessed online 10 November 2020. https://babel.hathitrust.org/cgi/pt?id=nnc2.ark:/13960/t3nw25n19&view=2up&seq=522).



PLAN OF THE FIRST FLOOR OF THE PHIPPS PSYCHIATRIC WARD.

A garden, a loggia and a terrace form unique and attractive features of the first floor plan. Here are located the general office, the examination and admission rooms, a clinical laboratory, and separate treatment rooms.

Image 3: The first-floor layout of the Phipps Clinic. Note the outpatient entrance and the clinical laboratory on bottom left hand side, the student entrance on the opposite side, and the numerous examination rooms, and the large admission wards on either side. "The Henry Phipps Psychiatric Ward at Johns Hopkins", 514. (Courtesy of the HathiTrust. Accessed online 10 November 2020. https://babel.hathitrust.org/cgi/pt?id=nnc2.ark:/13960/t3nw25n19&view=2up&seq=522).

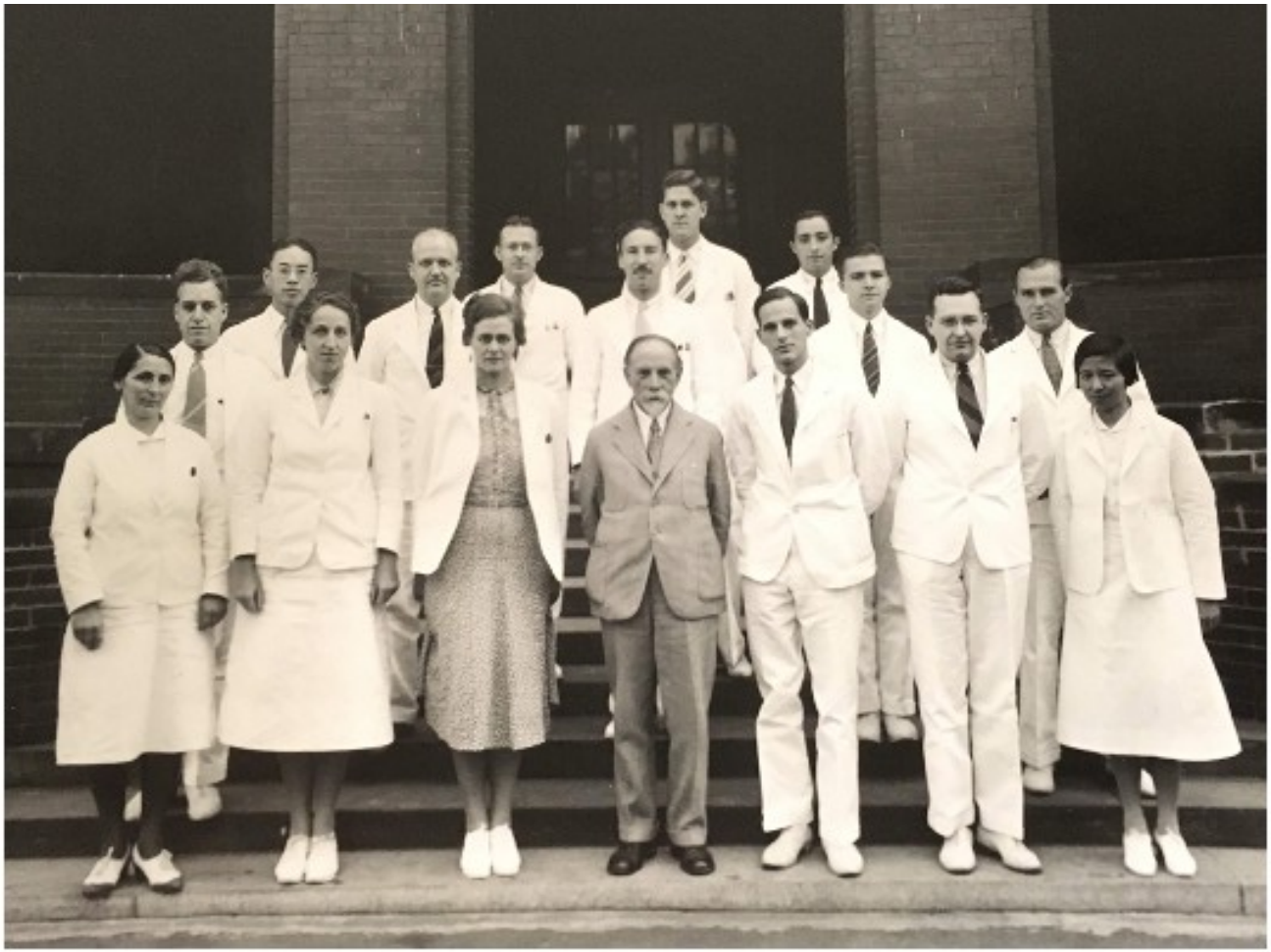
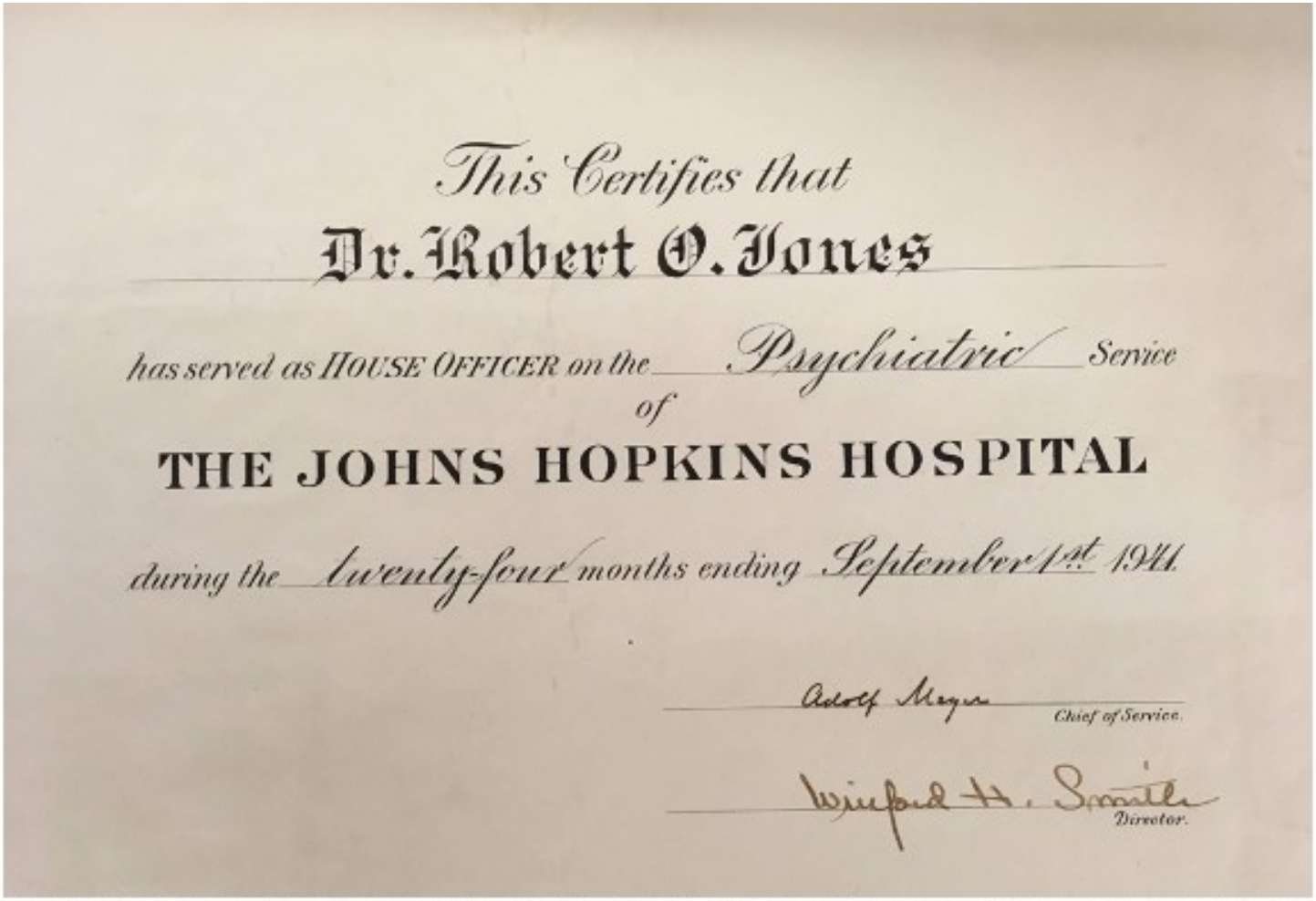


Image 4: Adolf Meyer and Robert O. Jones in a Johns Hopkins University Medical School Department of Psychiatry Residents class photo for the year 1940-1941. Meyer is pictured at the front in grey and in the middle, while Jones is second from right hand side in the front row. DUA Jones, MS 13 14, Box 98, Folder 11, Photographs - Oversize, Adolf Meyer at John Hopkins 1939-1940 and 1940-1941, Residents and 1939-1941. (Courtesy of the Robert O. Jones Fonds, Dalhousie University Archives).



This Certifies that

Dr. Robert O. Jones

has served as HOUSE OFFICER on the Psychiatric Service

of

THE JOHNS HOPKINS HOSPITAL

during the twenty-four months ending September 1st 1941

Adolf Meyer
Chief of Service.

Winfred H. Smith
Director.

Image 5: The certification which Jones received from Johns Hopkins and signed by Meyer which indicates that Jones completed his training in psychiatry at the institution. DUA Jones, MS 13 14, Oversize Box 9, Folder 14, "A certificate from John Hopkins Hospital from his time servicing as House Officer in the psychiatric Service," (1941). (Courtesy of the Robert O. Jones Fonds, Dalhousie University Archives).

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